MARYLAND SCHOOL FOR THE DEAF
MEDICAL INSURANCE INFORMATION
SCHOOL YEAR 2017-2018

Child's Name:_____
(Last) (First) (Middle)

Date of Birth: _____ Child's Age: _____ Grade: _____

Health Insurance Information	**Insurance Provider**	**Prescription Drug plan**	**Other Insurance**
Name of Company Address and Phone Number			
Policy Number			
Name of Policy Holder			
Family Physician's Name, Address and phone #			
Health Concerns, Allergies, Restrictions			
Date of last Tetanus Shot:	Date of Last Physical Exam:		

(NOTE: Student must have a completed current physical exam form to participate in any sport.)

*****Please attach a photo copy of all insurance cards, both front and back.**

Consent for Medical Care:
In case of injury or sudden illness, I hereby authorize medical care to be provided by MSD Healthcare personnel. Further, I grant permission for any hospital or treatment facility to render immediate aid or emergency surgical care as might be required at the time for his/her health and safety. I understand that in order for medications to be administered, they must in the original pharmacy bottle with label attached and dated within one year. I also understand that over the counter medications must be accompanied with a written order form a physician. I give my permission for MSD personnel to administer such medications. Attempts to notify parents/guardians regarding a medical emergency will always begin immediately.

_____ _____
Parent/Guardian's Signature Date

cc: Student Support Services
Health Center

Revised: 6/23/2017