CCL 010 Rev. 2/2010 Kansas Department of Health and Environment

Child Care Licensing and Registration Program 1000 SW Jackson, Suite 200

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AUTHORIZATION FOR EMERGENCY MEDICAL CARE

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A) except School Age Programs reference K.A.R. 28-4-582(e)(2)(B).

Name of facility exactly as stated on the license/certificate.		License or Certificate #
nereby authorize (Name of individual/staff member) and/or		
	(Name of individual/staff member	er) who is (are) representative(s) of the
above named facility to give consent for any and all necess	sary emergency medical care for my ch	ild or youth
	t and Last Name of Child or Youth) whi	•
·	•	io data di iia di youti io iii data taoiity d
custody between the dates of	and MM/DD/YYYY	·
Signature of Parent or Guardian		Date Signed
Witness to Parent's or Guardian's signature only if reclinic.	equired by the local hospital or	Date Signed
Notarization of Parent's or Guardian's signature only it	f required by local hospital or clinic.	
State of Kansas		
County of		
Signed or attested before me onMM/DD/YY	YY Name of Pers	son
(Seal, if any.)		
	Signature of notarial office	cer
	Title (and Rank)	
	My appointment expires:	
Complete information regarding health care insurance	if annlicable	
Health Insurance Policy Name:		y Number
Medical Assistance Program		
Military Medical Care I.D. Number		
If known, date of last Tetanus inoculation:		
List any known allergies or other information about the	e medical status of this child or yout	th pertinent in case of emergency:

THE MEDICAL RECORD/ASSESSMENT FORM (OR HEALTH STATUS HISTORY FORM FOR SCHOOL AGE PROGRAMS) AND THE AUTHORIZATION FOR EMERGENCY MEDICAL CARE MUST BE TAKEN TO THE EMERGENCY ROOM. BOTH FORMS MUST ALSO

BE IN A VEHICLE WHEN THE CHILD OR YOUTH IS TRANSPORTED BY THE FACILITY.