



**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). School Age Programs reference K.A.R. 28-4-582(e)(2).

Name of facility exactly as stated on the license.	License #
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I hereby authorize \_\_\_\_\_ (Name of individual/staff member) and/or \_\_\_\_\_ (Name of individual/staff member) who is (are) representative(s) of the above named facility to give consent for any and all necessary emergency medical care for my child or youth \_\_\_\_\_ (First and Last Name of Child or Youth) while said child or youth is in said facility's custody between the dates of \_\_\_\_\_ MM/DD/YYYY and \_\_\_\_\_ MM/DD/YYYY.

<b>Signature of Parent or Guardian</b>	Date Signed
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<b>Witness to Parent's or Guardian's signature if required by the local hospital or clinic.</b>	Date Signed
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**Notarization of Parent's or Guardian's signature if required by local hospital or clinic.**

State of Kansas  
County of \_\_\_\_\_

Signed or attested before me on \_\_\_\_\_ by \_\_\_\_\_  
MM/DD/YYYY Name of Person

(Seal, if any.)

\_\_\_\_\_  
Signature of notarial officer

\_\_\_\_\_  
Title (and Rank)

My appointment expires: \_\_\_\_\_

**List any known allergies or other information about the medical status of this child or youth pertinent in case of emergency:**

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**Is child covered by health insurance?**  Yes  No

**If yes, complete the following:**

Health Insurance Policy Name \_\_\_\_\_ Policy Number \_\_\_\_\_  
Medical Assistance Program \_\_\_\_\_ Card Number \_\_\_\_\_  
Military Medical Care I.D. Number \_\_\_\_\_

**If known, date of last Tetanus inoculation:** \_\_\_\_\_

**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.**