CCL 010
Rev. 5/2020

Kansas Department of Health and Environment
Bureau of Family Health
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Child Care Program: (785) 296 -1270 Fax: (785) 559-4244
Website: www.kdheks.gov/kidsnet

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 #**
Northridge Family Development Center	0060494-016

I authorize Northridge FDC Teachers/Staff ______________________ (*caregiver/staff*) 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________________________________ (*child's first and last name)* while child or youth is in the facility's custody between ____________________ and until termination of services. .
MM/DD/YYYY MM/DD/YYYY

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: ______________________
MM/DD/YYYY

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

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Signature of Parent or Guardian	**Date Signed**

Witness to Parent's or Guardian's signature if required by the local hospital or clinic.	**Date Signed**
N/A	N/A

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 N/A ______________________.
MM/DD/YYYY Name of Person

(Seal, if any.)

____
Signature of notarial officer

____
Title (and Rank)

My appointment expires: ______________________

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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.