



**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 #
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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 \_\_\_\_\_ and \_\_\_\_\_

MM/DD/YYYY	MM/DD/YYYY
Signature of Parent or Guardian	Date Signed

Witness to Parent's or Guardian's signature only if required by the local hospital or clinic.	Date Signed
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Notarization of Parent's or Guardian's signature only if required by local hospital or clinic.

State of Kansas	County of _____	Signed or attested before me on _____ by _____ (Seal, if any.)	Name of Person _____	Signature of notarial officer _____	Title (and Rank) _____	My appointment expires: _____
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Complete information regarding health care insurance, if applicable.

Health Insurance Policy Name: \_\_\_\_\_ Policy Number \_\_\_\_\_

Medical Assistance Program \_\_\_\_\_ Card Number \_\_\_\_\_

Military Medical Care I.D. Number \_\_\_\_\_

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

List any known allergies or other information about the medical status of this child or youth 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.**