

**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) 296 -0803  
Foster Care Program: (785) 296 -1270 Fax: (785) 296 -7025  
Website: www.kdheks.gov/kidsnet



★ **Required Information**

**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).

<b>Name of facility exactly as stated on the license.</b> Lakeside Sports Day Camp	<b>License #</b>
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I hereby authorize SCP+R Staff (Name of individual/staff member) and/or Lakeside Sports Day Camp Staff (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 06/06/2021 and 07/31/2021.  
MM/DD/YYYY MM/DD/YYYY

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

<u>State of Kansas</u> 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: _____
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★ List any known allergies or other information about the medical status of this child or youth pertinent in case of emergency:  
\_\_\_\_\_

★ 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.**