

Kansas Department for Children and Families

Foster Care Licensing Division
500 SW Van Buren St • 2nd Floor • Topeka, KS
66603 Fax: (785) 296-8609
Website: <http://www.dcf.ks.gov>



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).

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 _____ and _____.
MM/DD/YYYY MM/DD/YYYY

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

State of <u>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: _____

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 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.