FCL 010 Rev. 01/22

Kansas Department for Children and Families



Foster Care Licensing Division PO BOX 1424 ● Topeka, KS 66601-1424
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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).

Vitness to Parent's or Guardian's signature if required by the local hospital or clinic. Date Signed Date S	lame of facility exactly as stated on the	license.		License #
Child covered by health insurance? Yes No yes, complete the following: Health Insurance Policy Name Policy Number Medical Assistance Program Card Number Medical Assistance Program Medical Assistance Prog	ereby authorize		(Nar	ne of individual/staff member) and/or
Child covered by health insurance? Yes No yes, complete the following: Health Insurance Policy Name Policy Number Medical Assistance Program Card Number Medical Assistance Program Medical Assistance Prog			(Name of individual/staff mem	ober) who is (are) representative(s) of the
(First and Last Name of Child or Youth) while said child or youth is in said fa stody between the dates of and MM/DD/YYYY	pove-named facility to give consent for any		•	
stody between the dates of		-		•
Vitness to Parent's or Guardian's signature if required by the local hospital or clinic. Date Signed Vitness to 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		•	,	,
Vitness to Parent's or Guardian's signature if required by the local hospital or clinic. Date Signed Vitness to 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	istody between the dates of	ai	nd	·
State of Kansas County of	Signature of Parent or Guardian	5/1111	WWW.DD/TTT	
State of Kansas County of Signed or attested before me on by	Witness to Parent's or Guardian's signa	ture if required by th	e local hospital or clinic.	Date Signed
State of Kansas County of Signed or attested before me on by				
State of Kansas County of Signed or attested before me on by	otarization of Parent's or Guardian's sig	inature if required by	local hospital or clinic	
Signed or attested before me on		naturo ir roquirou by	ioual hoopital of office.	
MM/DD/YYYY Name of Person (Seal, if any.) Signature of notarial officer Title (and Rank) My appointment expires: st any known allergies or other information about the medical status of this child or youth pertinent in case of emergence child covered by health insurance? Yes No yes, complete the following: Health Insurance Policy Name Policy Number Medical Assistance Program Card Number Military Medical Care I.D. Number	County of			
MM/DD/YYYY Name of Person (Seal, if any.) Signature of notarial officer Title (and Rank) My appointment expires: st any known allergies or other information about the medical status of this child or youth pertinent in case of emergence child covered by health insurance? Yes No yes, complete the following: Health Insurance Policy Name Policy Number Medical Assistance Program Card Number Military Medical Care I.D. Number	Signed or attested before me on		by	
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Title (and Rank) My appointment expires:	(Seal, if any.)			
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child covered by health insurance?			My appointment expires	s:
Wes, complete the following: Health Insurance Policy Name Policy Number Medical Assistance Program Card Number Military Medical Care I.D. Number	tst any known allergies or other informa	tion about the medic	al status of this child or you	uth pertinent in case of emergency:
Wes, complete the following: Health Insurance Policy Name Policy Number Medical Assistance Program Card Number Military Medical Care I.D. Number				
Health Insurance Policy Name Policy Number Medical Assistance Program Card Number Military Medical Care I.D. Number	child covered by health insurance?	Yes 🗌 No		
Medical Assistance Program Card Number Military Medical Care I.D. Number	yes, complete the following:			
Military Medical Care I.D. Number	Health Insurance Policy Name		Pol	licy Number
	Medical Assistance Program		(Card Number
known, date of last Tetanus inoculation:	Military Medical Care I.D. Number			
	known, date of last Tetanus inoculation	1:		

TO THE EMERGENCY ROOM. BOTH FORMS MUST ALSO BE IN A VEHICLE WHEN THE CHILD OR YOUTH IS TRANSPORTED BY THE FACILITY.