

CCL 010 Rev. 8/2013

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



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.		Civitan Day Camp		License #
			•	69814
hereby authorizeS	CP+R Staff		(Na	ame of individual/staff member) and/or
Civitan Day Camp Staff		(Name o	of individual/staff me	ember) who is (are) representative(s) of t
bove named facility to give cons	ont for any and all mass-	,		
toove named facility to give cons				
		nd Last Nam	e of Child or Youth)	while said child or youth is in said facilit
ustody between the dates of	05/31/2021	and	08/14/2021	
MM/DD/YYYY Signature of Parent or Guardian			MM/DD/YYYY	Date Signed
organization of the transfer of country	par i			Date Orgined
Witness to Devention of Occurs	ando olematicus lá comeles de	urtha laasi i	recuital er allala	Data Cianad
Witness to Parent's or Guardi	an's signature it required t	y the local I	nospital or clinic.	Date Signed
lotarization of Parent's or Gua	rdian's signature if require	d by local h	ospital or clinic.	
State of Kansas County of				
County of				
Signed or attested before me	e on	by		
Signed or attested before me	e on MM/DD/YYYY		Name of F	Person
Signed or attested before me (Seal, if any.)	A 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Name of F	Person
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(Seal, if any.)	MM/DD/YYYY	Signa Title (a	ture of notarial off and Rank) pointment expires	icer
(Seal, if any.)	MM/DD/YYYY	Signa Title (a	ture of notarial off and Rank) pointment expires	icer 3:
(Seal, if any.)	MM/DD/YYYY	Signa Title (a	ture of notarial off and Rank) pointment expires	icer
(Seal, if any.)	MM/DD/YYYY	Signa Title (a	ture of notarial off and Rank) pointment expires	icer
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(Seal, if any.)	MM/DD/YYYYY	Signa Title (a	ture of notarial off and Rank) pointment expires	icer
(Seal, if any.) (Seal, if any.) List any known allergies or other schild covered by health insurf yes, complete the following: Health Insurance Policy	er information about the m	Signa: Title (a My ap	ture of notarial off and Rank) pointment expires s of this child or y	colicy Number
(Seal, if any.) (Seal, if any.) List any known allergies or other schild covered by health insurf yes, complete the following: Health Insurance Policy	er information about the m	Signa: Title (a My ap	ture of notarial off and Rank) pointment expires s of this child or y	s:outh 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.