CCL 010 Rev. 5/2020 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) 559-4244



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.		L	icense #	
Gan Chabad Preschool	W.W.		0019105	
authorize Menachem or Devora Wir	neberg, Esty Perma	n, Julie Krashin or any	staff member (CE	aregiver/staff) wh
s (are) representative(s) of the above-nam	ed facility to give cons	sent for any and all necess	sary emergency medical care	for my child or
outh	(child's		child or youth is in the facility	
08/01/2017 and	07/30/2029		ulina di Janes	
MM/DD/YYYY	MM/DD/YYYY			
s child covered by health insurance?]Yes □ No			
f yes, complete the following:			Dellas Mumber	
	Health Insurance Policy Name		Policy Number	
Military Medical Care I.D. Number				
f known, date of last Tetanus inoculation:	C)		773	
Kriowii, date of last retains shoulding.	MM/DD/	YYYY		
Signature of Parent or Guardian			Date Signed	
DATE OF THE STREET				
Witness to Bossetic or Coundingle size	•	_		
witness to Parent's or Guardian's sign	ature if required by t	the local hospital or clini	c. Date Signed	
Witness to Parent's or Guardian's sign	ature if required by t	the local hospital or clini	c. Date Signed	
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Notarization of Parent's or Guardian's s State of Kansas County of	ignature if required b	by local hospital or clinic		
Notarization of Parent's or Guardian's s State of Kansas County of	ignature if required b	by local hospital or clinic	E.	
Notarization of Parent's or Guardian's s State of Kansas County of Signed or attested before me on	ignature if required b	by local hospital or clinic	of Person	
Notarization of Parent's or Guardian's s State of Kansas County of Signed or attested before me on	ignature if required b	by local hospital or clinic by Name of	of Person	
Notarization of Parent's or Guardian's s State of Kansas County of Signed or attested before me on	ignature if required b	by local hospital or clinic by by Name o	of Person	

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.