



**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. <b>Heritage Preschool</b>	License # <b>0037218-001</b>
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I hereby authorize **Cathy Lancelotta** (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 **until no longer enrolled at Heritage Preschool**  
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 Kansas  
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: \_\_\_\_\_