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).

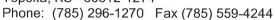
Name of facility exactly as stated on the license.		Lie	cense #
Lincoln Center		C	0783SD-00A
		HEN	(caregiver/staff) who
is (are) representative(s) of the above-named facility to g	ive consent for any	and all necessary emerge	ency medical care for my child or
youth	_(child's first and la	st name) while child or yo	outh is in the facility's custody
between 10 05 2020 and 08 3	112021 YYYY		
ls child covered by health insurance? ☐ Yes ☐ No			
If yes, complete the following: Health Insurance Policy Name		Policy Νι	umber
Medical Assistance Program			lumber
Military Medical Care I.D. Number			
If known, date of last Tetanus inoculation:			
	MM/DD/YYYY		
List any known allergies or other information about t	he medical condit	ions of this child or you	th pertinent in case of emergency:
Signature of Parent or Guardian		Da	ate Signed
			lia 9.19
Witness to Parent's or Guardian's signature if requi	red by the local ho	spital or clinic. Da	ate Signed
Notarization of Parent's or Guardian's signature if rec	auired by local ho	spital or clinic.	
State of Kansas	7		
County of			
Signed or attested before me on	by		
MM/DD/Y		Name of Person	
(Seal, if any.)		Name of Ferson	
(Ocal, il ally.)			
	Cianat		
	Signatu	re of notarial officer	
	Title (ar	nd Rank)	
		ointment expires:	
	wy app	omunem expires	-

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.

CCL. 358 Rev. 5/2020

Kansas Department of Health and Environment

Bureau of Family Health Child Care Licensing Program 1000 SW Jackson, Suite 200 Topeka, KS 66612-1274



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HEALTH HISTORY FOR CHILDREN AND YOUTH ATTENDING SCHOOL AGE PROGRAMS

As required by K.A.R. 28-4-590(d) (1), each operator shall obtain a health history for each child or youth, on a form supplied by the department or approved by the secretary. Each health history is to be maintained in the child's or youth's file on the premises. As required by K.A.R. 28-4-590(d)(2), each operator shall require that each child or youth attending the program has current immunizations as specified in K.A.R. 28-1-20 or has an exemption for religious or medical reasons.

			e of the Child or Youth		Gender (M or F)	Date of Birth (MM/DD/YYYY)	First day at this program: (MM/DD/YYYY)
First	and La	st Name	e of the Child's or Youth's Mother or G	Suardian			
Moth	er/Gua	rdian's I	Home Street Address	City		Zip Code	Home Phone #
Moth	er/Gua	rdian's \	Work Place Name & Street Address	City		Zip Code	Work Phone #
First	and La	st Name	e of the Child's or Youth's Father or G	uardian			
Fathe	er/Guar	dian's H	Home Street Address	City		Zip Code	Home Phone #
Fathe	∍r/Guar	dian's V	Nork Place Name & Street Address	City		Zip Code	Work Phone #
Name	s and a	ages of	other children in the Child or Youth's	Family (Atta	ach additiona	I page if needed	.)
case Stree	of eme	rgency.	ed to pick up the Child or Youth in Include first and last name and ach additional page if needed.	City		Zip Code	Phone Number (during program hours):
1. 2.							
3.							
First	and Las	st Name	e of Physician & Street Address	City		Zip Code	Phone Number
Name	of Hos	spital Pr	reference in case of emergency.				
Yes	No	N/A	Complete the following information	about med	lications for t	his child or yout	h.
			Will this child or youth need to take an program?		iption or presc	ription medication	during their time at the
			If yes above, is there signed permission	on on file?			

Allergie	Frequent sore throats/ colds	Ear Infections or Act		nes l	Heart or Lung Conditions	
Skin Pr	oblems Asthma	Headaches	5	Diabetes		
/ision	Speech/Communication	Hearing	Hearing		Emotion/Behavior	
Other: F	Please describe.			L		
	ircled any of the above conditions, please provide add or youth's needs while attending the program. (Attacl				ne staff me	embers meet the
ncludin	e additional information about your child or youth that ng any special needs, restrictions to activities, major o i needed.	might affect changes at ho	him/her w ome or spe	hile at the S ecial instruc	chool Age tions. (Att	Program tach additional
nplete t	the following information about this child's or youth's	immunizatio	n status.			
	Did this child or youth attend a public or acc the previous year? If yes, are this child's or youth's immunization		public sch	ool in Kans	as, Missou	ıri or Oklahoma
	If yes to both of these questions, you do NO If no to either of the above questions, you m youth or attach a copy of the child's or youth	T need to cor ust complete	the immu	nization his	on history tory below	below. v for this child c
ase give	e dates in the space below for ALL immunization series	es completed	by this ch	ild or youth		
		1	2	3	4	5
	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	1 1	1 1	1 1	1 1
	POLIO	1 1	1 1	/ /	1 1	
	MMR	1 1	1 1			
Single	RUBEOLA (MEASLES)	1 1	1 1			
Dose						
Only	MUMPS	/ /	/ / /	_		
	RUBELLA (GERMAN MEASLES)	11	1 / /	_		
	HIB (Hemophilus Influ, B) *RECOMMENDED	11	11			
					/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	1 1	/ /	/ /		
	VAR (Varicella-Chicken Pox) *RECOMMENDED	1 1				
l		141 111 4	form	Relationsh	in to the	Date Complete
rint the	First and Last Name of the Person Completing this H	ealth History	101111	Child/Yout		Date Complete
the He	e First and Last Name of the Person Completing this H ealth History form was completed by a person other th evided you with this information?			Child/Yout	h nat person	's relationship t