



**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.  Lincoln Center	License #  0078350-003
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I authorize Pittsburg Parks and Recreation (caregiver/staff) 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 (child's first and last name) while child or youth is in the facility's custody between 08/14/2023 and 08/16/2024.  
MM/DD/YYYY MM/DD/YYYY

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: \_\_\_\_\_  
MM/DD/YYYY

List any known allergies or other information about the medical conditions of this child or youth pertinent in case of emergency:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Parent or Guardian	Date Signed
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<del>Witness to Parent's or Guardian's signature if required by the local hospital or clinic.</del>	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: \_\_\_\_\_

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.



**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.

**Complete one form for each child or youth attending the School Age Program.**

<b>First and Last Name of the Child or Youth</b>	<b>Gender (M or F)</b>	<b>Date of Birth (MM/DD/YYYY)</b>	<b>First day at this program: (MM/DD/YYYY)</b>
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<b>First and Last Name of the Child's or Youth's Mother or Guardian</b>
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<b>Mother/Guardian's Home Street Address</b>	<b>City</b>	<b>Zip Code</b>	<b>Home Phone # ( )</b>
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<b>Mother/Guardian's Work Place Name &amp; Street Address</b>	<b>City</b>	<b>Zip Code</b>	<b>Work Phone # ( )</b>
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<b>First and Last Name of the Child's or Youth's Father or Guardian</b>
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<b>Father/Guardian's Home Street Address</b>	<b>City</b>	<b>Zip Code</b>	<b>Home Phone # ( )</b>
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<b>Father/Guardian's Work Place Name &amp; Street Address</b>	<b>City</b>	<b>Zip Code</b>	<b>Work Phone # ( )</b>
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<b>Names and ages of other children in the Child or Youth's Family (Attach additional page if needed.)</b>
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<b>Person(s) authorized to pick up the Child or Youth in case of emergency. Include first and last name and Street Address. Attach additional page if needed.</b>	<b>City</b>	<b>Zip Code</b>	<b>Phone Number (during program hours):</b>
1.			
2.			
3.			

<b>First and Last Name of Physician &amp; Street Address</b>	<b>City</b>	<b>Zip Code</b>	<b>Phone Number ( )</b>
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<b>Name of Hospital Preference in case of emergency.</b>
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Yes	No	N/A	<b>Complete the following information about medications for this child or youth.</b>
			Will this child or youth need to take any nonprescription or prescription medication during their time at the program?
			If yes above, is there signed permission on file?

Circle any of the following conditions or difficulties that affect this child or youth.			
Allergies	Frequent sore throats/ colds	Ear Infections or Aches	Heart or Lung Conditions
Skin Problems	Asthma	Headaches	Diabetes
Vision	Speech/Communication	Hearing	Emotion/Behavior
Other: Please describe.			

If you circled any of the above conditions, please provide additional information that will help the staff members meet the child's or youth's needs while attending the program. (Attach additional page, if needed.)

Provide additional information about your child or youth that might affect him/her while at the School Age Program including any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.)

Complete the following information about this child's or youth's immunization status.

Yes	No	
		Did this child or youth attend a public or accredited non-public school in Kansas, Missouri or Oklahoma the previous year?
		If yes, are this child's or youth's immunizations current?
X	X	If yes to both of these questions, you do NOT need to complete the immunization history below. If no to either of the above questions, you must complete the immunization history below for this child or youth or attach a copy of the child's or youth's immunization history.

Please give dates in the space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.

		1	2	3	4	5
	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO	/ /	/ /	/ /	/ /	
	MMR	/ /	/ /			
Single Dose Only	RUBEOLA (MEASLES)	/ /	/ /			
	MUMPS	/ /	/ /			
	RUBELLA (GERMAN MEASLES)	/ /	/ /			
	HIB (Hemophilus Infl. B) *RECOMMENDED	/ /	/ /	/ /	/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /				

<b>Print the First and Last Name of the Person Completing this Health History form</b>	<b>Relationship to the Child/Youth</b>	<b>Date Completed</b>

If the Health History form was completed by a person other than a Parent/Guardian, who provided you with this information?	What is that person's relationship to the child/youth?

I attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct.

<b>Signature of person completing this form</b>	<b>Date Signed</b>



**PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS**

Name of the Facility (exactly as stated on the license) Lincoln Center			License # 0078350-005	
Street Address of the Facility 710 W 9th St	City Pittsburg	Zip Code 66762	County Crawford	

\_\_\_\_\_ may go to the following locations off the premises **with** adult supervision:

**First and Last Name of Child or Youth**

Place Lincoln Park	Street Address 813 Memorial Dr.	City Pittsburg	By Vehicle	Walk/Bike Walk
Signature of Parent or Guardian			Date Signed	

Place Fouroaks Golf Course	Street Address 910 Memorial Dr.	City Pittsburg	By Vehicle	Walk/Bike Walk
Signature of Parent or Guardian			Date Signed	

Place Kiddieland Amusement Park	Street Address 801 Memorial Dr.	City Pittsburg	By Vehicle	Walk/Bike Walk
Signature of Parent or Guardian			Date Signed	

Place Pittsburg Aquatic Center	Street Address 708 W 9th St.	City Pittsburg	By Vehicle	Walk/Bike Walk
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

**RELEASE**

Name of Participant: \_\_\_\_\_

In consideration of the use of my likeness, and for other good and valuable consideration herein acknowledged as received, I hereby grant, in perpetuity, to Pittsburg Parks and Recreation., its successors and assigns, exclusive authority and permission as follows:

**I perpetually and irrevocably give Pittsburg Parks and Recreation, my consent and authorization to take photos of my child to use for promotion of Parents Night Out on all Pittsburg Parks and Recreation Social Media sites or other printed materials.**

I waive any right to see or approve any recording of my likeness and any materials in which my likeness is used. I agree and understand that my likeness may be modified or distorted and that my own name, a fictitious name, or no name may be used in association with my likeness.

I irrevocably release, discharge, and hold Pittsburg Parks and Recreation, from any claims, demands, or causes of action that I may now have or may hereafter have for defamation, slander, libel, invasion of privacy or right of publicity, copyright infringement, or any other right arising out of or relating to the use of my likeness.

By signing this Release, I agree and represent that I can enter this contract in my own name, that I have read this Release and fully understand its contents, and that this Release shall be binding upon me and my heirs, legal representatives, and assigns.

**If the Participant is Under the Age of 18 Years:**

I warrant that I am the parent or legal guardian of the above-named person (the "Participant"), and I irrevocably consent to and authorize all of the foregoing on behalf of Participant and myself.

Name of Parent/Legal Guardian: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



