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).

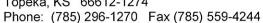
Name of facility exactly as stated on the license.	License #
Lincoln Center	0078350-003
l authorizePittsburg Parks and Recreation	(caregiver/staff) who
is (are) representative(s) of the above-named facility to give consent for any and all	
youth(child's first and last nam	(e) while child or youth is in the facility's custody
between <u>08/14/2023</u> and <u>08/16/2024</u>	
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:	_
List any known allergies or other information about the medical conditions of	f this child or youth pertinent in case of emergency:
Signature of Parent or Guardian	Date Signed
Witness to Parent's or Guardian's signature if required by the local hospital	or clinic. Date Signed
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	
100	Name of Person
(Seal, if any.)	
Signature of	notarial officer
Title (and Ra	nk)
My appointm	ent 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.

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Kansas Department of Health and Environment

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



Website: www.kdheks.gov/kidsnet



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.

omp	ete or	e form	for each child or youth attending	the School			T
First a	ind Las	st Name	of the Child or Youth		Gender (M or F)	Date of Birth (MM/DD/YYYY)	First day at this program: (MM/DD/YYYY)
First a	ind Las	st Name	of the Child's or Youth's Mother or G	uardian			
Mothe	r/Guar	dian's F	lome Street Address	City		Zip Code	Home Phone #
Mother/Guardian's Work Place Name & Street Address			City		Zip Code	Work Phone #	
First a	and Las	st Name	of the Child's or Youth's Father or G	uardian			
Fathe	r/Guaro	dian's H	ome Street Address	City		Zip Code	Home Phone #
Fathe	r/Guar	dian's W	ork Place Name & Street Address	City Zip C		Zip Code	Work Phone #
Name	s and a	iges of o	other children in the Child or Youth's	Family (Atta	ch additiona	al page if needed	.)
case	of eme	rgency.	d 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):
2.			· · · · · · · · · · · · · · · · · · ·				
3.		(B)					
First and Last Name of Physician & Street Address				City		Zip Code	Phone Number ()
Name	of Hos	spital Pr	eference in case of emergency.				
Yes	No	N/A	Complete the following information	about medi	cations for	this child or yout	h.
	Will this child or youth need to take any nonprescription or prescription medication during their time at the program?					n during their time at the	
			If yes above, is there signed permission on file?				

Allergies	Frequent sore throats/ colds	Ear Infections or Aches	Heart or Lung Conditions
Skin Problems	Asthma	Headaches	Diabetes
Vision	Speech/Communication	Hearing	Emotion/Behavior

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.

who provided you with this information?

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		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.

duties in the space select for ALL minum and account	1				5
	1	2	3	4	3
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	1 1	
MMR	1 1	11			1
RUBEOLA (MEASLES)	1 1	1 1			
MUMPS	1 1	1.1			
RUBELLA (GERMAN MEASLES)	1 1	1.1			
HIB (Hemophilus Influ. B) *RECOMMENDED	1.1	1 1	1 1	11	
HBV (Hepatitis B Vaccine) *RECOMMENDED	1.1	1 1	1 1		n
VAR (Varicella-Chicken Pox) *RECOMMENDED	1.1			귀	
	DPT, DT*, TD (*DT only if child is allergic to DTP) POLIO MMR RUBEOLA (MEASLES) MUMPS RUBELLA (GERMAN MEASLES) HIB (Hemophilus Influ. B) *RECOMMENDED HBV (Hepatitis B Vaccine) *RECOMMENDED	DPT, DT*, TD (*DT only if child is allergic to DTP) POLIO MMR / / RUBEOLA (MEASLES) / / MUMPS RUBELLA (GERMAN MEASLES) / / HIB (Hemophilus Influ. B) *RECOMMENDED / / HBV (Hepatitis B Vaccine) *RECOMMENDED	1 2	1 2 3	DPT, DT*, TD (*DT only if child is allergic to DTP) / / / / / / / / / / / / / / / / / / /

, internet in the carrier and a second a second and a second a second and a second a second a second and a second a second	Relationship to the Child/Youth	Date Completed	
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 the child/youth?	's relationship to	
who provided you with this information?	ine ciliuryoutii:		

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

Signature of person completing this form **Date Signed**

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Kansas Department of Health and Environment Bureau of Family Health

Child Care Licensing Program 1000 SW Jackson, Suite 200 Topeka, KS 66612-1274 Phone: 785-296-1270 Fax



Fax: 785-559-4244

Website: www.kdheks.gov/kidsnet

PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS

Name of the Facility (exactly as stated on the license) License #							
Lincoln Center					007	8350-005	
Street Address of the Facility		City		Zip Code		County	
710 W 9th St	Pittsburg		66762		Crawford		
	may	go to the following	g locations	off the prei	mises	s with adul	t supervision:
First and Last Name of Child or	Youth	-					
Place Lincoln Park	Street Address 813 Memoria		City Plttsburg		Ву	/ehicle	Walk/Bike Walk
Signature of Parent or Guardian					Date	e Signed	
	1						T
Place Fouroaks Golf Course	Street Address 910 Memori		City Pittsburg	1	By \	Vehicle	Walk/Bike Walk
Signature of Parent or Guardian	To to Monion	<u> </u>	T According	,	Date	e Signed	1
Place Kiddieland Amusement Park	Street Address 801 Memoria			By Vehicle		Walk/Bike Walk	
Signature of Parent or Guardian	ou i wemona	DI. Tittsburg		Date Signed			
Place	Street Address		City		Ву	Vehicle	Walk/Bike
Pittsburg Aquatic Center	708 W 9th S	St.	Pittsburg	}	Dat	- Cianad	Walk
Signature of Parent or Guardian				l l	Date	e Signed	
					l		
Place	Street Address	S	City		Ву	Vehicle	Walk/Bike
. 5. 556.506							
Signature of Parent or Guardian					Dat	e Signed	
Place	Street Address	s	City		Bv.	Vehicle	Walk/Bike
T lace	Oliver Address	•	J Sity		_,		
Signature of Parent or Guardian				Dat	e Signed		
The state of the s	104		l 0:4.		Levi	Vahial-	Molle/Dile
Place	Street Addres	5	City		By	Vehicle	Walk/Bike
Signature of Parent or Guardian	1		1		Dat	e Signed	1

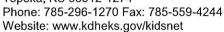
RELEASE

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:

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Kansas Department of Health and Environment

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





Authorization for Dispensing Medications to Children and Youth Short-Term Medications (Prescription and Non-Prescription)

<u>Prescription medication</u> must be in their original containers labeled with the child's/youth's first and last name; the name of the licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN) who ordered the medication; the date the prescription was filled; the expiration date of the medication; and specific, legible instructions for administration and storage of the medication. Administer the medication only to the child/youth designated on the prescription label in accordance with the instructions on the label. <u>Non-prescription medications</u> can be given with written permission and direction from the parent or legal guardian. Administer nonprescription medication from the original container labeled with the first and last name of the child/youth and according to the instructions on the label.

Medication #1	Medication #2
First and Last Name of Child/Youth Date of Birth	First and Last Name of Child/Youth Date of Birth
Name of Medication	Name of Medication
Reason for Medication	Reason for Medication
Dose Time to be Given Stop Date	Dose Time to be Given Stop Date
Name of Licensed Physician/PA/APRN prescribing the medication () Phone Number of Physician, PA, or APRN	Name of Licensed Physician/PA/APRN prescribing the medication () Phone Number of Physician, PA or APRN
I allow the above medication to be given to my child/youth by the designated person.	I allow the above medication to be given to my child/youth by the designated person.
Parent's Signature Date	Parent's Signature Date

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION(S) IDENTIFIED ABOVE. Designated Person to note any comments or remarks about the child's/youth's appearance on the back of this form. *Each designated person administering medication is to sign on the back side of this form and identify initials used.

Date mm/dd/yy	Time	Name of Medication	*Initials	Date mm/dd/yy	Time	Name of Medication	*Initials

*Signature	of Designated Person Administering Medication	Initialing as
*Signature	of Designated Person Administering Medication	Initialing as
*Signature	of Designated Person Administering Medication	Initialing as
*Signature	of Designated Person Administering Medication	Initialing as
	Note Form	
D 1		LA d'estable Assertation
Date	Additional comments about the incident or other comments or remarks about the child's/youth's a	