TRANSPORTATION / EMERGENCY MEDICAL CARE
PERMISSION FORM

Central Kansas Mental Health Center • 809 Elmhurst Blvd. • Salina, Ks • 67401
Voice: (785) 823-6322 Fax: (785) 823-3109

Client Name: _____

Date of Birth: _____ SSN: _____

I hereby give my permission for transportation of the above named person during the course of receiving treatment from Central Kansas Mental Health Center (CKMHC).

In the event of an emergency, the above-named person may receive medical and surgical care for any illness or injury when I am not available for consent.

Medical Information

Designated Physician: _____

Address: _____

_____

Allergies: _____

Chronic Health Problems: _____

Last Tetanus Shot: _____

(Medical information provided above is current as of the date this form is signed.)

CKMHC will exercise due care, caution, and supervision. However, CKMHC will assume no responsibility for accident or illness.
This consent continues for the course of treatment, unless revoked.

_____ _____

Parent/Guardian Date Witness Date

Original to be filed in clinical chart.