CCL. 029
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Kansas Department of Health and Environment
Child Care Licensing and Registration Program
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MEDICAL RECORD FOR ALL CHILDREN IN CHILD CARE FACILITIES AND FAMILY DAY CARE HOMES, INCLUDING PROVIDER'S OWN CHILDREN

Parents are to complete the Medical Record and the History of Immunizations for each child in registered family day care homes or licensed child care facilities. The Medical Record, History of Immunizations, and Child Health Assessment are transferable when the child moves to another licensed child care facility or family day care home.

Child's First Day in Child Care____________________ Name of Child Care Facility_____________________

Child's Name___________________________________ Date of Birth____________________ Gender_____
First Last MM/DD/YYYY M/F

Parent/Guardian Information	**Parent/Guardian Information**
Name________________________________	Name________________________________
Home Address__________________________ Street City Zip Code	Home Address__________________________ Street City Zip Code
Home Phone Number_____________________	Home Phone Number_____________________
Work Address__________________________ Street City Zip Code	Work Address__________________________ Street City Zip Code
Work Phone Number_____________________	Work Phone Number_____________________
Cell Phone Number______________________	Cell Phone Number______________________
E-mail Address ________________________	E-mail Address________________________
Best way to contact_____________________	Best way to contact_____________________

Names and ages of children in family____

Persons authorized to pick up the child or to notify in case of emergency. Include name, address, and telephone number. Attach an additional page, if necessary.____

____

Child's Physician______________________________ Phone Number______________________________

Child's Dentist_______________________________ Phone Number______________________________

Hospital Preference (for emergencies)____

1. Has your physician approved the use of any non-prescription medications for your child such as acetaminophen, cough syrup, or ointments that can be given by the child care provider? ___No ___Yes, as follows:

____

2. Does your child have any of the following conditions? Please answer yes or no.

_______Allergies _______Frequent sore throats/colds _______Ear Aches
_______Asthma _______Speech, Visual, Hearing _______Diabetes
_______Epilepsy/Seizures _______Other____________________________

If yes answered to any above, please provide additional information_____________________________

3. Have there been major changes at home that might affect your child in care? ____ No ___Yes, as follows:

____

4. Please provide additional information or special instructions that will help the person caring for your child.

____

Signature of Parent/Guardian____Date:______________

History of Immunizations

For all children in child care facilities and family day care homes, including the provider's own children. A Kansas Certificate of Immunizations (KCI) may be substituted for this form and attached to the completed Medical Record.

Child's Name:____**Date of Birth:** ________________

First Last MM/DD/Y

SECTION I.

Vaccine	**Record the Month. Day and Year that each Dose of Vaccine was Received**					
	1st	**2nd**	**3rd**	**4th**	**5th**	**6th**
DTaP/DT/Td/Tdap (Diphtheria, Tetanus, Pertussis)						
Polio						
MMR (Measles, Mumps, and Rubella combined)						
HBV (Hepatitis B Vaccine)						
Varicella (Chicken Pox)			Hx of Disease: Physician Signature		Date of Illness:	
HIB (Hemophilus Influenzae Type B)						
PCV7 (Pneumococcal Conjugate)						
HEP A (Hepatitis A)						
Rotavirus **Recommended <8 mo of age; not required						
Influenza(Flu) ** Recommended annually >6 mo of age; not required						

Section II. Complete this section only if your child is exempted from the laws requiring immunizations [K.S.A. 65-508(d) and K.S.A. 65-519(c)].

The following two options are the **ONLY** exemptions allowed by law. **Please check either (A) or (B) below and complete as required:**

☐ **(A) Certification from licensed physician stating that immunization would endanger child's life:**
Exempt from following immunizations:

_____DTP _____Pertussis Only _____Tetanus _____Polio _____MMR _____Rubella Only _____Hep A _____Hep B

Hib _____PCV7 _____Other

Physician's Signature (required): ______________________________________**Date:**______________

☐ **(B) My child is exempt under the law from immunizations. As the Parent or Legal Guardian, I state that I am an adherent of a religious denomination whose teachings are opposed to immunizations.**

Section III.

Parent/Guardian Signature:____**Date:**__________

Child Health Assessment

The Child Health Assessment form is to be completed and signed by a nurse approved by KDHE to perform Child Health Assessments or a Licensed Physician. If a Physician Assistant (PA) completes the Child Health Assessment, the signature of the Licensed Physician authorizing the PA is to be included at the bottom of this form.

A Child Health Assessment, recorded on a KDHE Form or other acceptable Forms mentioned below, is required for all children including children of the provider or staff in Licensed Day Care Homes, Group Day Care Homes, Child Care Centers and Preschools. A Child Health Assessment is optional for children in Registered Family Day Care Homes. A Kan-Be-Healthy Assessment Form is a KDHE Form and is acceptable, a Physician Health Assessment Form is acceptable, and a School Health Assessment Form is acceptable for school-age children or youth. Any Health Assessment Form should be attached to the KDHE Medical Record Form.

Child's Name______________________________ Date of Birth______________________________

Past Health History (Developmental – Illness – Hospitalization)______________________________________

Allergies____

Current Medications____

Nutritional Status____

Physical Examination

Height__________ Weight__________

Head_________________________________ Abdomen_______________________________

EENT_________________________________ GU____________________________________

Teeth_________________________________ GYN___________________________________

Heart_________________________________ Skeletal_______________________________

Lungs_________________________________ Neurological___________________________

Screening Tests (Dates Done and Results)

Vision________________________________ TBC. Test______________________________

Hearing_______________________________ Sickle Cell_____________________________

Speech________________________________ HGB.___________________________________

DDST_________________________________ U.A.___________________________________

Lead__________________________________ Other__________________________________

Diagnosis:

Recommendation:

Do you see this child for regular health supervision: Yes ______ No ______

____ ______________________

Signature of Licensed Physician or Nurse Approved for Child Health Assessments Date (MM/DD/YYYY)

____ Phone number_____________

Print the Name of the Individual Signing Above

____

Address of Physician or Nurse City Zip Code