CCL. 029
Rev. 8/2013

Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
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Kansas
Department of Health and Environment

MEDICAL RECORD FOR ALL CHILDREN IN CHILD CARE FACILITIES, INCLUDING PROVIDER'S OWN CHILDREN

Parents are to complete the Medical Record and the History of Immunizations for each child in 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.

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)____

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:

____

Does your child have any of the following conditions (yes or no)? If yes, provide information on Authorization for Emergency Medical Care form CCL. 010.

_______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____

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

____

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

____

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

History of Immunizations

Required for all children in child care facilities, 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/YYYY

Section I. For a recommended schedule of immunizations, refer to the current schedule published by the Advisory Committee on Immunization Practices (ACIP).

Vaccine	**Record the Month. Day and Year that each Dose of Vaccine was Received**					
	1st	**2nd**	**3rd**	**4th**	**5th**	**6th**
Diphtheria, Tetanus, Pertussis (DTaP)						
Poliomyelitis (IPV/OPV)						
Measles, Mumps, Rubella (MMR)						
Hepatitis B (HepB)						
Varicella (VAR)			Hx of Disease: Physician Signature		Date of Illness:	
Hemophilus Influenzae Type B (Hib)						
Pneumococcal Conjugate (PCV)						
Hepatitis A (HepA)						
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 law requiring immunizations [K.S.A. 65-508(d)].

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:

_____DTaP/DT _____Tdap/TD ____Pertussis Only ____Polio ____MMR ____HepA ____HepB ____Hib

_____PCV ____Varicella ____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:**________________

CCL. 029a
Rev. 8/2013

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 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. The Health Assessment Form used should be attached to the KDHE Medical Record Form (CCL. 029).

Child's Name____________________________________ **Date of Birth**________________
First Last

Health history and medical information pertinent to routine child care and emergencies (describe, if any): ☐ None	Do you see this child for regular health supervision: ☐ Yes ☐ No
Allergies to food or medicine (describe, if any): ☐ None	
List current medications (if any): ☐ None	

Length/Height: ______ IN/CM %ILE______		**Weight: _____LB/KB %ILE______**
Physical Examination	✓ **If Normal**	**If Abnormal - Comments**
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardio/Respiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic & Developmental		
Screening Tests	**Screening Date**	**Note Here if Results are Pending or Abnormal**
Lead		
Anemia (HGB/HCT)		
Urinalysis (UA)		
Hearing		
Vision		

Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (Attach additional sheets if necessary) ☐ None		
Signature of Licensed Physician or Nurse approved for Child Health Assessments		Date
Print the Name of the Individual Signing Above		Phone Number
Address	City	Zip Code