CCL. 029 Rev. 08/2024 Child Care Licensing Program
Curtis State Office Building
Kansas Department of Health and Environment
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## Medical Record Medical History

In accordance with K.A.R. 28-4-117 and K.A.R. 28-4-430, a completed medical record shall be on file for all children in care. For a Family Child Care Home, children under 10 years of age and all children living in the home under 16 years of age, a medical record shall be completed. The Medical Record shall include a Medical History including current Immunizations and a Child Health Assessment. The Medical Record is transferable when the child moves to another licensed child care facility.

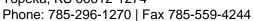
Child's First Day in Child Care		Name of Child Care Facility			
Child's NameFirst	Last	Date of Birth	MM/DD/VV	Ger	ider
Parent/Guardian Information		Date of Birth Gender MM/DD/YYYY M/F  Parent/Guardian Information			
Name					
Home Address					
Street City			Street	City	Zip Code
Home/Cell Phone Number		Home/Cell Phone	Number		
Work Phone Number	Work Phone Number				
E-mail Address	E-mail Address				
Best way to contact	Best way to contact				
Persons authorized to pick up the	child or to notify i	n case of emergenc	cy (other th	an the parent	·s):
Name	<del>-</del>	Name		<del>-</del>	-
Address		Address			
Phone Number		Phone Number			
Child's Physician		_ Phone Number _			
Hospital Preference (for emergencies):					
Known allergies or medical conditions:					
Major changes at home that might affect your child in care:					
Additional information or special instructions that will help the person caring for your child:					
Parent/Guardian Signature:			D	ate:	
Date of annual review:	Parent/Guardian Initials:		Provider Initials:		
Date of annual review:	Parent/Guardian Initials:		Provider Initials:		
Date of annual review:	Parent/Guardian Initials:		Provider Initials:		
Date of annual review:	Parent/Guardian Initials:		Provider Initials:		

## **Medical Record:**

## **Medical History Cont. - 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). Record the Month. Day and Year that each Dose of Vaccine was Received **Vaccine** 2<sup>nd</sup> 3<sup>rd</sup> 4<sup>th</sup> **Diphtheria, Tetanus, Pertussis** (DTaP) **Poliomvelitis** (IPV/OPV) Measles, Mumps, Rubella (MMR) **Hepatitis B** (HepB) Varicella Hx of Disease: Date of Illness: (VAR) Physician Signature Hemophilus Influenzae Type B (Hib) Pneumococcal Conjugate (PCV) Hepatitis A (HepA) Rotavirus \*Recommended <8 mo.; not required Influenza (Flu) \*Recommended annually >6 mo.; not required Section II. Complete this section only if your child is exempted from the law requiring immunizations [K.S.A. 65-508(g)]. 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: Pe<u>rtus</u>sis Only Polio MMR Tdap/TD DTaP/DT \_Varicella \_ Other (describe): \_\_\_\_\_ 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: \_\_\_\_\_

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## Medical Record: Child Health Assessment

The Child Health Assessment form is to be completed and signed by a nurse approved to perform health assessments, a licensed physician, or physician's assistant (PA). The health assessment shall be conducted not more than 12 months before and no later than 60 calendar days after enrollment at the child care facility.

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 Family Child 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.

Child's Name		Date of Birth					
First	La	st					
(describe, if any):  None							
Allergies to food or medicine (describe, if any):  None							
List current medications (if any):  None							
Length/Height:IN/CM %ILE_		Weight:LB/KG %I	LE				
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 P	ending or Abnormal				
Lead							
Anemia (HGB/HCT)							
Urinalysis (UA)							
Hearing							
Vision							
Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (Attach additional pages if necessary)							
☐ None							
Signature of Licensed Physician or Nurse approved for Child Health Assessment			Date				
Print the Name of the Individual Signing Above			Phone Number				
Address	City		Zip Code				