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________________________ Gender________________________ Date of Birth________________________ MM/DD/YYYY
First
Last

Parent/Guardian Information

Name________________________
Home Address________________________
Street
City
Zip Code
Home Phone Number________________________
Work Address________________________
Street
City
Zip Code
Work Phone Number________________________
Cell Phone Number________________________
E-mail Address________________________
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:________________________

CCL. 029
Rev. 5/2019
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 (785) 559-4244
Website:  www.kdheks.gov/kidsnet
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: ___________________________ 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).

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Record the Month. Day and Year that each Dose of Vaccine was Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria, Tetanus, Pertussis (DTaP)</td>
<td></td>
</tr>
<tr>
<td>Poliomyelitis (IPV/OPV)</td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps, Rubella (MMR)</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B (HepB)</td>
<td></td>
</tr>
<tr>
<td>Varicella (VAR)</td>
<td>Hx of Disease: ___________________________ Physician Signature: ___________</td>
</tr>
<tr>
<td>Hemophilus Influenza Type B (Hib)</td>
<td></td>
</tr>
<tr>
<td>Pneumococcal Conjugate (PCV)</td>
<td></td>
</tr>
<tr>
<td>Hepatitis A (HepA)</td>
<td></td>
</tr>
<tr>
<td>Rotavirus</td>
<td>**Recommended &lt;8 mo of age; not required</td>
</tr>
<tr>
<td>Influenza(FLU) ** Recommended annually &gt;6 mo of age; not required</td>
<td></td>
</tr>
</tbody>
</table>

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:
  _____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: ___________
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).

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Health history and medical information pertinent to routine child care and emergencies (describe, if any):

- □ None

Allergies to food or medicine (describe, if any):

- □ None

List current medications (if any):

- □ None

<table>
<thead>
<tr>
<th>Length/Height:______ IN/CM %ILE_______</th>
<th>Weight:______ LB/KG %ILE_______</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Examination</td>
<td></td>
</tr>
<tr>
<td>✓ If Normal</td>
<td>If Abnormal - Comments</td>
</tr>
<tr>
<td>Head/Ears/Eyes/Nose/Throat</td>
<td></td>
</tr>
<tr>
<td>Teeth</td>
<td></td>
</tr>
<tr>
<td>Cardio/Respiratory</td>
<td></td>
</tr>
<tr>
<td>Abdomen/GI</td>
<td></td>
</tr>
<tr>
<td>Genitalia/Breasts</td>
<td></td>
</tr>
<tr>
<td>Extremities/Chords/Back/Chest</td>
<td></td>
</tr>
<tr>
<td>Skin/Lymph Nodes</td>
<td></td>
</tr>
<tr>
<td>Neurologic &amp; Developmental</td>
<td></td>
</tr>
</tbody>
</table>

Screening Tests Screen 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