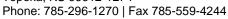
CCL. 029 Rev. 08/2024 Child Care Licensing Program
Curtis State Office Building
Kansas Department of Health and Environment
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274



Email: kdhe.cclr@ks.gov | kdhe.ks.gov/ChildCareLicensing



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. Please fill-in EVERY line on this form. If the information is not applicable, please note that

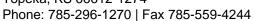
Child's First Day in Child Care Child's Name		Name of Child Care Facility <u>FHSU Tiger Tots Preschool C</u> er			
		Date of Birth		Gend	Gender
First	Last		MM/DD/YYYY	1	M/F
Parent/Guardian Information		Parent/Guardian Information			
Name		Name			
Home Address					
Street Cit	y Zip Code	S	Street	City	Zip Code
Home/Cell Phone Number		Home/Cell Phone	Number		
Work Phone Number		Work Phone Num	ber		
E-mail Address		E-mail Address			
Best way to contact		Best way to contact			
Persons authorized to pick up the	e child or to notify i	n case of emergenc	y (other thar	the parents	s):
Name		Name			
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:			Dat	:e:	
Date of annual review:	Parent/Guardi	an Initials:	Provider	Initials:	
Date of annual review:	Parent/Guardi	an Initials:	Provider	Initials:	
Date of annual review:	Parent/Guardi	an Initials:	Provider	Initials:	
Date of annual review:	Parent/Guardi	an 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 2nd 3rd 4th **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						
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/KG %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 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					