CCL. 029
Rev. 02/2026

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 at the facility for each child. For a Family Child Care Home, a completed medical record shall be on file for each child under 10 years of age enrolled for care and for each child under 16 years of age living in the child care facility. The medical record shall include a medical history, a record of 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 Name_____
First Last

Date of Birth_____ Gender_____
MM/DD/YYYY M/F

Parent/Guardian Information

Name_____

Home Address_____
Street City Zip Code

Home/Cell Phone Number_____

Work Phone Number_____

E-mail Address_____

Best way to contact_____

Parent/Guardian Information

Name_____

Home Address_____
Street City Zip Code

Home/Cell Phone Number_____

Work Phone Number_____

E-mail Address_____

Best way to contact_____

Persons authorized to pick up the child or to notify in case of emergency (other than the parents):

Name _____

Address _____

Phone Number _____

Name _____

Address _____

Phone Number _____

Child's Physician_____

Phone Number_____

Hospital Preference (for emergencies)_____

Any known allergies or medical conditions of child: _____

_____

Any major changes at home that might affect your child in care: _____

_____

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

_____

Parent/Guardian Signature: _____Date: _____

Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____
Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____
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Medical Record

Medical History (continued) - Immunizations

Child's Name:_____ Date of Birth: _____
First Last MM/DD/YYYY

Immunizations for each child in care shall be current as medically appropriate and shall be maintained current for protection from the diseases specified in K.A.R. 28-1-20(d).
A Kansas Certificate of Immunizations (KCI) may be substituted for this form and attached to the completed Medical Record.

Vaccine	Record the date (MM/DD/YY) each dose of vaccine was received				
	1st	2nd	3rd	4th	5th
Diphtheria, Tetanus, Pertussis (DTaP)					
Haemophilus influenzae type b (Hib)					
Hepatitis A (Hep A)					
Hepatitis B (Hep B)					
Measles, Mumps, Rubella (MMR)					
Pneumococcal disease (PCV15, PCV20)					
Poliomyelitis (IPV)					
Varicella (VAR)					
Respiratory syncytial virus (RSV) – Recommended, not required					
Rotavirus (RV) – Recommended, not required					
Influenza – Recommended, not required					

I attest that to the best of my knowledge the immunization information entered is true and correct.

Parent/Guardian Signature: _____ Date: _____

If your child is exempted from the law requiring immunizations, K.S.A. 65-508(g), check either (A) or (B) below and complete as required.

☐ (A) Certification from licensed physician stating that immunization would endanger the child's life. Child is exempt from the following immunizations:

_____DTaP _____Hib ___Hep A ____Hep B ___MMR ___PCV15/PCV20 ____IPV ____VAR

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.

Parent/Guardian Signature: _____ Date: _____