CCL. 029
Rev. 5/2019

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

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_____

**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)? <u>If yes, provide information on Authorization for Emergency Medical Care form CCL. 010</u>.

_____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(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:**_____

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## 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):<br>☐ None | Do you see this child for regular health supervision:<br>☐ Yes ☐ No |
|---|---|
| Allergies to food or medicine (describe, if any):<br>☐ None | |
| List current medications (if any):<br>☐ 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 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)<br>☐ 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 |