CCL. 029 Rev. 5/2020 Kansas Department of Health and Environment Bureau of Family Health Facilities 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



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 August 30, 2023	Name of Child Care Facility Sancta Maria School, Inc.			
Child's Name	Date of Birth Gender			
First Last	MM/DD/YYYY M/F			
Parent/Guardian Information	Parent/Guardian Information			
Name	Name			
Home Address	Home Address			
Street City Zip Code	Street City Zip Code			
Home Phone Number	Home Phone Number			
Employer	Employer			
Work Phone Number	Work Phone Number			
Cell Phone Number	Cell 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 in Name Address Phone Number	case of emergency (other than the parents): Name Address Phone Number			
Child's Physician	Phone Number			
Child's Dentist	Phone Number			
Hospital Preference (for emergencies)				
Has your physician approved the use of any non-prescription syrup, or ointments that can be given by the child care provi				
Any known allergies or medical conditions of child:				
Any major changes at home that might affect your child in ca	are:			
Please provide additional information or special instructions t	hat will help the person caring for your child:			

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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					
	1 st	2 nd	3 rd	4 th	5 th	6 th
Diphtheria, Tetanus, Pertussis (DTaP)						
Poliomyelitis (IPV/OPV)						
Measles, Mumps, Rubella (MMR)					,	
Hepatitis B (HepB)						
Varicella (VAR)			Hx of Disease: Date of Illness: Physician Signature		Iness:	
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/DTTdap/TDPertussis OnlyPolioMMRHepAHepB <u>Hib</u> PCVVaricellaOther
Physician's Signature (required):Date:

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 at (describe, if any):	nd emergencies Do you see this child for regular health supervision:
None Allergies to food or medicine (describe, if any):	Tes No
List current medications (if any):	
□ None	

Length/Height:IN/CM %ILE		Weight:LB/KG %ILE		
Physical Examination	✓ If Normal	If Abnormal - Comment	ts	
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)				
□ None				
Signature of Licensed Physician or Nurse approved for Child Health Assessments		ealth Assessments	Date	
Print the Name of the Individual Signing Above			Phone Number	
Address	Iress City		Zip Code	