CCL. 029 Rev. 8/2013

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) 296-0803



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		· · · · · · · · · · · · · · · · · · ·	Name of Child Care Facility				
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	,	•	Street	•	·		
Home Phone Number			Home Phone Number				
Work Address			Work AddressStreet	City	Zip Code		
Street	City	Zip Code		•	-		
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				
Attach an additional page, if nec Child's Physician			Phone Number				
Child's Dentist			Phone Number				
Hospital Preference (for emerge	encies)						
Has your physician approved th syrup, or ointments that can be	e use of any no given by the cl	on-prescription hild care provid	medications for your child su der?NoYes, as foll	ch as acetamin ows:	ophen, cough		
Does your child have any of the Emergency Medical Care form C Allergies Asthma Epilepsy/Seizures If yes answered to any above, p	CCL, 010. 	Frequent sore Speech, Visua Other	throats/colds I, Hearing	on on Authoriza Ear A Diabe	ches		
Have there been major changes				_Yes, as follow	ıs:		
Please provide additional inform	nation or specia	i instructions t	nat will neip the person caring	y ioi your cillia			

Required for all children in child c	are facilities	s. including ti	ne provider's o	wn children. A	Kansas Certific	ate of	
Immunizations (KCI) may be sub	stituted for	this form and	attached to th	e completed M	edical Record.		
Child's Name:				Dat	e of Birth:		
First			Last	A CONTRACTOR OF THE CONTRACTOR	Address-Testino	MM/DD/YYYY	
Section I. For a recommended Advisory Committee on Immu				the current	schedule publi	ished by the	
Vaccine	Record the Month. Day and Year that each Dose of Va					accine was Received	
Diphtheria, Tetanus, Pertussis	1 st	2 nd	3 rd	4 th	2	6	
(DTaP)	<u> </u>				Mark 100 (100 (100 (100 (100 (100 (100 (100		
Poliomyelitis (IPV/OPV)					7.5		
Measles, Mumps, Rubella (MMR)						an and the second	
Hepatitis B (HepB)							
			Hx of Dise	ase:	Dati	e of Illness:	
Varicella (VAR)			Physician		and 4-DNY-SINGH MONTH DOOR 12-DA		
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							
The following two options are the complete as required: (A) Certification from lice Exempt from following immunization immunization provided immunication	e ONLY executes ensed physions: Pertuss	emptions allow	ved by law. Pi	ease check ei	ther (A) or (B)) below and	
Physician's Signature (require	ed):				Date:_		

____Date:____

Parent/Guardian Signature:_____

Section III.

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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	d's Name							
First	Las	st .						
Health history and medical information pe (describe, if any):	Do you see this child for regular health supervision:							
None			☐ Yes ☐ No					
Allergies to food or medicine (describe, if	any):							
☐ None								
List current medications (if any):								
□ None								
1								
Length/Height:IN/CM %:	ILE	Weight:LB/KB	%ILE					
Physical Examination	Y If Normal	If Abnormal - Commen						
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 ar	e Pending or Abnormal					
Lead								
Anemia (HGB/HCT)								
Urinalysis (UA)								
Hearing								
Vision								
Health Problems or Special Needs, Recom	mended Treatment/	Medications/Special Care (A	ttach additional sheets if necessary)					
☐ None								
Signature of Licensed Physician or Nurse	Date							
Print the Name of the Individual Signing A	Phone Number							
Address	ddress City							