

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.

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/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): _____

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: _____ **Date:** _____

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

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Medical History Cont. - Immunizations

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: Physician Signature		Date of Illness:		
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:

☐ DTaP/DT ☐ Tdap/TD ☐ Pertussis Only ☐ Polio ☐ MMR ☐ Hep A ☐ Hep B
☐ Hib ☐ PCV ☐ 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: _____

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 Last

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 Pending 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