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			Name of Child Care Facility					
Child's Name				Date of Birth	Gender			
	First	Last		MM/DD/YYYY	M/F			
Parei	nt/Guardian Info	rmation		Parent/Guardian Informati	on			
Name				Name				
Home Address				Home Address				
	Street	City	Zip Code	Street Cit				
Home Phone Number				Home Phone Number				
Employer				Employer				
Work Phone Number				Work Phone Number				
Cell Phone Number	er			Cell Phone Number				
E-mail Address				E-mail Address				
Best way to conta	act			Best way to contact				
Name Address Phone Number Child's Physician	ized to pick up th			Name Address Phone Number				
Has your physicia	n approved the use	of any non-p	orescription	medications for your child such as acetar ler?NoYes, as follows:				
Any known allerg	ies or medical cond	itions of child	:					
Any major change	es at home that mig	jht affect you	ır child in ca	re:				
Please provide ac	Iditional information	or special in	structions th	nat will help the person caring for your ch	nild:			
Parent/Guardia	nn Signature:			Date:				

History of Immunizations

Required for all children in child care facilities, including the provider's own children. A Kansas C	ertificate of
Immunizations (KCI) may be substituted for this form and attached to the completed Medical Re	cord.

Child's Name:				Dat	te of Birth:	
First			Last			MM/DD/YYYY
ection I. For a recommended dvisory Committee on Immu				to the current	schedule pub	lished by the
Vaccine				ear that each Do	se of Vaccine	was Received
Vaccine	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)						
	1		Hx of Dis	sease:	Da	ite of Illness:
Varicella (VAR)				Signature	50	te of Imiessi
emophilus Influenzae Type B (Hib)						
Pneumococcal Conjugate (PCV)						
Hepatitis A (HepA)						
otavirus **Recommended <8 mo of age; not required						
Influenza(Flu) ** Recommended annually >6 mo of age; not required						
The following two options are th complete as required:	e ONLY exe	emptions allo	owed by law. P	lease check ei	ther (A) or (B) below and
(A) Certification from lice Exempt from following immuniza		ician statin	g that immun	ization would	endanger chi	ld's life:
DTaP/DTTdap/TD	Pertus	sis Only	PolioM	IMRHepA	НерВ	Hib
PCVVaricellaO	ther					
Physician's Signature (require	ed):				Date:	
DTaP/DTTdap/TD	Pertuss	,			·	
/ child is exempt un	ider the las	w from imp	unizatione A	s the Darent o	r Legal Guard	lian Tetato
nat I am an adherent of a re						
ection III.						
Parent/Guardian Signature:					Date:	

CCL. 029a Rev. 05/2020

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	Las	st						
Health history and medical information po (describe, if any):	ertinent to routine ch	ild care and emergencies	Do you see this child for regular health supervision:					
None			☐ Yes ☐ No					
Allergies to food or medicine (describe, if	any):							
None	□ None							
List current medications (if any):								
None								
		1						
Length/Height:IN/CM %	ILE	Weight:LB/KG %ILE						
Physical Examination	✓ 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, Recommended Treatment/Medications/Special Care (Attach additional sheets if necessary)								
□ None								
Signature of Licensed Physician or Nurse approved for Child Health Assessments Date								
Print the Name of the Individual Signing		Phone Number						
Address	City	Zip Code						