



## Medical Record Medical History

In accordance with K.A.R. 28-4-117, a completed medical record shall be on file for all children in care under 10 years of age and all children living in the home under 16 years of age. 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) \_\_\_\_\_

Any known allergies or medical conditions of child: \_\_\_\_\_

Any major changes at home that might affect your child in care: \_\_\_\_\_

Please provide 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 Record:

## Medical History Cont. - 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 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	5 <sup>th</sup>	6 <sup>th</sup>
<b>Diphtheria, Tetanus, Pertussis (DTaP)</b>						
<b>Poliomyelitis (IPV/OPV)</b>						
<b>Measles, Mumps, Rubella (MMR)</b>						
<b>Hepatitis B (HepB)</b>						
<b>Varicella (VAR)</b>			Hx of Disease: Physician Signature		Date of Illness:	
<b>Hemophilus Influenzae Type B (Hib)</b>						
<b>Pneumococcal Conjugate (PCV)</b>						
<b>Hepatitis A (HepA)</b>						
<b>Rotavirus</b> <b>**Recommended &lt;8 mo.; not required</b>						
<b>Influenza (Flu)</b> <b>**Recommended annually &gt;6 mo.; not required</b>						

### 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

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): <input type="checkbox"/> None	Do you see this child for regular health supervision: <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to food or medicine (describe, if any): <input type="checkbox"/> None	
List current medications (if any): <input type="checkbox"/> 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) <input type="checkbox"/> 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

