



## 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

### Parent/Guardian Information

Name \_\_\_\_\_

Name \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City Zip Code

Home Address \_\_\_\_\_  
Street City Zip Code

Home/Cell Phone Number \_\_\_\_\_

Home/Cell Phone Number \_\_\_\_\_

Work Phone Number \_\_\_\_\_

Work 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 case of emergency (other than the parents):

Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

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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Date of annual review: \_\_\_\_\_ Parent/Guardian Initials: \_\_\_\_\_ Provider Initials: \_\_\_\_\_



## 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)  
 None

Signature of Licensed Physician or Nurse approved for Child Health Assessment	Date
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Print the Name of the Individual Signing Above	Phone Number
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Address	City	Zip Code
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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>
Diphtheria, Tetanus, Pertussis (DTaP)						
Polio (IPV/OPV)						
Measles, Mumps, Rubella (MMR)						
Hepatitis B (HepB)						
Varicella (VAR)						
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

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: \_\_\_\_\_



### Authorization for Emergency Medical Care

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A). School Age Programs reference K.A.R. 28-4-582(e)(2).

Name of facility exactly as stated on the license <i>Monticello Preschool</i>	License # <i>0026487</i>
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I authorize *Rheanna Manson & Monticello Staff* (caregiver/staff) who is/are representative(s) of the above-named facility to give consent for any and all necessary emergency medical care for my child or youth \_\_\_\_\_ (child's first and last name) while child or youth is in the facility's custody between \_\_\_\_\_ and *NO END DATE* MM/DD/YYYY MM/DD/YYYY

List any known allergies or other information about the medical conditions of this child or youth pertinent in case of emergency:

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Signature of Parent or Guardian	Date Signed
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The Medical Record/Assessment Form (Or Health Status History form for School Age Programs) and the authorization for Emergency Medical Care must be taken to the emergency room. Both forms must also be in a vehicle when the child or youth is off premises from the facility.