



**MEDICAL RECORD FOR ALL CHILDREN IN DAY CARE FACILITIES
INCLUDING PROVIDER'S OWN CHILDREN**

Parents are to complete the medical record side of this form for each child in registered or licensed child care facilities.

Child's Name _____ Date of Birth _____ Gender _____
First Last MM/DD/YY

Mother/Guardian Name _____ Father/Guardian Name _____

Home Address _____
Street City Zip Code Street City Zip Code

Home Phone Number _____ Home Phone Number _____

Work Address _____
Street City Zip Code Street City Zip Code

Work Phone Number _____ Work Phone Number _____

Names and ages of children in family _____

Persons Authorized to pick up the child or to notify in case of emergency. Include name, address, and telephone number. Attach an additional page, if necessary. _____

Family Physician _____ Telephone Number _____

Hospital Preference (for emergencies) _____

- Has your physician approved the use of any non-prescription medications for your child such as acetaminophen, cough syrup, or Ointments, that can be given by the day care provider? No Yes, as follows _____
- Does your child have any of the following problems? Please answer with a yes or no.
 Allergies Frequent sore throats/colds Ear Aches
 Skin Problems Other _____ Other _____
 If yes, please provide additional information _____
- Have there been any major changes at home that might affect your child in care? No Yes, as follows _____
- Please provide additional information or special instructions that will help the person caring for your child _____
- Please give dates for ALL immunizations series completed by your child in the space below. Record MM/DD/YY.**

		<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
DPT, DT*, TD(*DT only if child is allergic to DPT)		//	//	//	//	//
POLIO		//	//	//	//	
MMR		//	//			
Single Dose Only	RUBEOLA (MEASLES)	//	//			
	MUMPS	//	//			
	RUBELLA (GERMAN MEASLES)	//	//			
HIB (Hemophilus Infl. B) *RECOMMENDED		//	//	//	//	
HBV (Hepatitis B Vaccine) *RECOMMENDED		//	//	//		
VAR (Varicella-Chicken Pox) *RECOMMENDED		//				

The Child Health Assessment 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, 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 Child Health Assessment is optional for children in Registered Family Day Care Homes. A Kan-Be-Healthy Assessment Form is a KDHE form and is acceptable. A School Health Assessment Form is also acceptable for school-age children or youth.

PAST HEALTH HISTORY (DEVELOPMENTAL – ILLNESS – HOSPITALIZATION)

ALLERGIES _____

CURRENT MEDICATIONS _____

NUTRITIONAL STATUS _____

PHYSICAL EXAMINATION:

HEIGHT _____

WEIGHT _____

HEAD _____

ABDOMEN _____

EENT _____

GU _____

TEETH _____

GYN _____

HEART _____

SKELETAL _____

LUNGS _____

NEUROLOGICAL _____

SCREENING TESTS (DATES DONE AND RESULTS)

VISION _____

TBC. TEST _____

HEARING _____

SICKLE CELL _____

SPEECH _____

HGB. _____

DDST _____

U.A. _____

OTHER _____

DIAGNOSIS:

RECOMMENDATION:

DO YOU SEE THIS CHILD FOR REGULAR HEALTH SUPERVISION: YES _____ NO _____

SIGNATURE OF LICENSED PHYSICIAN OR NURSE APPROVED BY KDHE TO PERFORM HA

DATE

PRINT THE NAME OF THE INDIVIDUAL SIGNING ABOVE

Phone # _____

ADDRESS OF PHYSICIAN OR NURSE

CITY

ZIP CODE

REVERSE SIDE OF FORM IS REQUIRED FOR EACH CHILD IN REGISTERED FAMILY DAY CARE HOMES, LICENSED DAY CARE AND GROUP DAY CARE HOMES, LICENSED DAY CARE AND GROUP DAY CARE HOMES, CHILD CARE CENTERS AND PRESCHOOLS.

PARENTS MAY TRANSFER THIS FORM WHEN THEIR CHILD MOVES TO ANOTHER REGULATED CHILD CARE FACILITY IN KANSAS.