

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 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

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: _____

Length/Height: <u> </u> IN/CM %ILE <u> </u>		Weight: <u> </u> LB/KG %ILE <u> </u>	
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