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 Little Friends Preschool of FBC Basehor

Child's Name____________________
First Last

Date of Birth____________________ Gender______
MM/DD/YYYY M/F

Parent/Guardian Information

Name____________________

Home Address____________________
Street City Zip Code

Home Phone Number____________________

Employer____________________

Work Phone Number____________________

Cell Phone Number____________________

E-mail Address ____________________

Best way to contact____________________

Parent/Guardian Information

Name____________________

Home Address____________________
Street City Zip Code

Home Phone Number____________________

Employer____________________

Work Phone Number____________________

Cell 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____________________

Child's Dentist____________________ Phone 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 child care provider? ____No ____Yes, as follows: ____________________

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:**____________

History of 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					
	1st	2nd	3rd	4th	5th	6th
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 of age; not required						
Influenza(Flu) ** Recommended annually >6 mo of age; 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 ____HepA _____HepB ____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:**______________

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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 Last

Health history and medical information pertinent to routine child care and emergencies (describe, if any): ☐ None	Do you see this child for regular health supervision: ☐ Yes ☐ No
Allergies to food or medicine (describe, if any): ☐ None	
List current medications (if any): ☐ 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 sheets if necessary)
☐ None

Signature of Licensed Physician or Nurse approved for Child Health Assessments	Date
Print the Name of the Individual Signing Above	Phone Number

Address	City	Zip Code

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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.	**License #**
Little Friends Preschool of FBC Basehor	7285

I authorize Little Friends Preschool 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 09/01/2024 (MM/DD/YYYY) and until no longer in care (MM/DD/YYYY)

Is child covered by health insurance? ☐ **Yes** ☐ **No**

If yes, complete the following:

Health Insurance Policy Name ______________ Policy Number ______________
Medical Assistance Program ______________ Card Number ______________
Military Medical Care I.D. Number ______________

If known, date of last Tetanus inoculation: ______________ (MM/DD/YYYY)

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

____
____
____

Signature of Parent or Guardian	**Date Signed**

Witness to Parent's or Guardian's signature if required by the local hospital or clinic.	**Date Signed**

Notarization of Parent's or Guardian's signature if required by local hospital or clinic.

State of Kansas
County of ______________

Signed or attested before me on ______________ (MM/DD/YYYY) by ______________ (Name of Person).

(Seal, if any.)

____
Signature of notarial officer

____
Title (and Rank)

My appointment expires: ______________

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 transported by the facility.

Little Friends Preschool
Developmental History

Child's Name ______________________________ ______________________________
Last First

Name child prefers ______________________ Birthdate ____________________

Parent Name ____

Address ____
City zip

E-mail address __________________________

Phone ______________________ Cell number ____________________________

Name and ages of siblings ____

Class preference: ___ T/TH-AM $150 ___T/TH-PM $150 ___ M/W/F-AM $180 ___ M/W/F PM $180

HEALTH:

Any serious illnesses or hospitalization? ______________________________

List any known allergies: ____

Any physical disabilities or limitations? ______________________________

Are there any known food allergies? ______________________________

TOILET HABITS:

Does the child indicate his/her bathroom needs? ________

LANGUAGE DEVELOPMENT:

Does he/she speak clearly? ________

Are there particular sounds or words that cause difficulty for the child? __________________

SOCIAL RELATIONSHIPS:

What experience has the child had in playing with other children: 1) his own age ____________

2) older ___________________________ 3) younger ___________________________

CHILD'S EXPECTATIONS:

Is the child excited about starting Preschool? ______________________________

Are there any concerns or hopes he/she has shared? ______________________________

YOUR EXPECTATIONS:

Do you feel he/she will adjust easily to Preschool? ______________________________

Are there any concerns that you would like to share? ______________________

What would you like the child to achieve this school year? ______________________________

____

____

Non-refundable $100 registration fee submitted check #______________ Cash __________
date _______