



**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 _____

Child's Name _____ Date of Birth _____ Gender _____
First Last MM/DD/YYYY M/F

Parent/Guardian Information

Parent/Guardian Information

Name _____ Name _____

Home Address _____ Home Address _____
Street City Zip Code Street City Zip Code

Home Phone Number _____ Home Phone Number _____

Work Address _____ Work Address _____
Street City Zip Code Street City Zip Code

Work Phone Number _____ Work Phone Number _____

Cell Phone Number _____ Cell Phone Number _____

E-mail Address _____ E-mail Address _____

Best way to contact _____ Best way to contact _____

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. See attached sheet

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:

Does your child have any of the following conditions (yes or no)? If yes, provide information on Authorization for Emergency Medical Care form CCL 010.

- | | | |
|--|--|------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Frequent sore throats/colds | <input type="checkbox"/> Ear Aches |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Speech, Visual, Hearing | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Other _____ | |

If yes answered to any above, please provide additional information _____

Have there been 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.

Parent/Guardian Signature: _____ Date: _____

Contact Information

➤ Child's Name: _____

➤ Parent/guardian: _____

➤ Telephone Number: _____

➤ Persons authorized to pick up your child or to notify in case of an emergency (at least two):

Name: _____

Address: _____

Telephone number: _____

Name: _____

Address: _____

Telephone number: _____

Name: _____

Address: _____

Telephone number: _____

Name: _____

Address: _____

Telephone number: _____

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): <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	

See attached sheet

Length/Height: _____ IN/CM %ILE	Weight: _____ LB/KB %ILE
Physical Examination	<input checked="" type="checkbox"/> If Normal <input type="checkbox"/> 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

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: _____
First Last Date of Birth: _____
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)						
Hemophilus Influenzae Type B (Hib)						
Pneumococcal Conjugate (PCV)						
Hepatitis A (HepA)						
Rotavirus <small>**Recommended <8 mo of age; not required</small>						
Influenza(Flu) <small>** Recommended annually >6 mo of age; not required</small>						

See attached sheet

Section II.

Complete this section only if your child is exempted from the law requiring immunizations [K.S.A. 65-508(d)].

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: _____



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. <u>St. Patrick Early Education Center</u>	License # <u>0000589-001</u>
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I hereby authorize Nena Scott (Name of individual/staff member) and/or EEC Staff (Name of individual/staff member) 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 _____

(First and Last Name of Child or Youth) while said child or youth is in said facility's custody between the dates of 08/01/2021 and 05/31/2024.
MM/DD/YYYY MM/DD/YYYY

Signature of Parent or Guardian	Date Signed
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Witness to Parent's or Guardian's signature if required by the local hospital or clinic.	Date Signed
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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 _____ by _____ <small>MM/DD/YYYY Name of Person</small>
(Seal, if any.)
Signature of notarial officer _____
Title (and Rank) _____
My appointment expires: _____

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

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: _____

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.



PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS

Name of the Facility (exactly as stated on the license)			License #	
St. Patrick Early Education Center			0000581-001	
Street Address of the Facility		City	Zip Code	County
1080 N. 94th Street		Kansas City	66112	Wyandotte

* _____ may go to the following locations off the premises with adult supervision:
First and Last Name of Child or Youth

Place	Street Address	City	By Vehicle	Walk/Bike
St. Patrick Big School	1066 N. 94th Street	KCK		<input checked="" type="checkbox"/>
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
St. Patrick Church	1080 N. 94th	KCK		<input checked="" type="checkbox"/>
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
St. Patrick Parish Center	1080 N. 94th	KCK		<input checked="" type="checkbox"/>
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Signature of Parent or Guardian			Date Signed	