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**Kansas Department of Health and Environment**
Child Care Licensing and Registration Program
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# MEDICAL RECORD FOR ALL CHILDREN IN CHILD CARE FACILITIES AND FAMILY DAY CARE HOMES, INCLUDING PROVIDER'S OWN CHILDREN

**Parents are to complete the Medical Record and the History of Immunizations for each child in registered family day care homes or 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 or family day care home.**

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 Phone Number_____

Work Address_____
Street City Zip Code

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_____

Work Address_____
Street City Zip Code

Work Phone Number_____

Cell Phone Number_____

E-mail Address_____

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._____

_____

Child's Physician_____ Phone Number_____

Child's Dentist_____ Phone Number_____

Hospital Preference (for emergencies)_____

1. 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:

_____

2. Does your child have any of the following conditions? Please answer yes or no.

_____Allergies _____Frequent sore throats/colds _____Ear Aches
_____Asthma _____Speech, Visual, Hearing _____Diabetes
_____Epilepsy/Seizures _____Other_____

If yes answered to any above, please provide additional information_____

3. Have there been major changes at home that might affect your child in care? ___ No ___Yes, as follows:

_____

4. Please provide additional information or special instructions that will help the person caring for your child.

_____

**Signature of Parent/Guardian**_____ **Date:**_____

## History of Immunizations

**For all children in child care facilities and family day care homes, 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/Y

**SECTION I.**

| Vaccine | Record the Month. Day and Year that each Dose of Vaccine was Received | | | | | |
|---|---|---|---|---|---|---|
| | 1st | 2nd | 3rd | 4th | 5th | 6th |
| **DTaP/DT/Td/Tdap** (Diphtheria, Tetanus, Pertussis) | | | | | | |
| **Polio** | | | | | | |
| **MMR** (Measles, Mumps, and Rubella combined) | | | | | | |
| **HBV** (Hepatitis B Vaccine) | | | | | | |
| **Varicella** (Chicken Pox) | | | Hx of Disease: Physician Signature | | Date of Illness: | |
| **HIB** (Hemophilus Influenzae Type B) | | | | | | |
| **PCV7** (Pneumococcal Conjugate) | | | | | | |
| **HEP A** (Hepatitis A) | | | | | | |
| **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 laws requiring immunizations [K.S.A. 65-508(d) and K.S.A. 65-519(c)].**

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:

_____DTP ____Pertussis Only ____Tetanus ____Polio ____MMR ____Rubella Only ____Hep A _____Hep B

Hib _____PCV7 ____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:**_____