

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 (describe): _____

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:** _____



Medical Record: Child Health Assessment

The Child Health Assessment form is to be completed and signed by a nurse approved to perform health assessments, a licensed physician, or physician's assistant (PA). The health assessment shall be conducted not more than 12 months before and no later than 60 calendar days after enrollment at the child care facility.

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 Family Child 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.

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 | |

| | | |
|--|---|--|
| Length/Height: _____ IN/CM %ILE _____ | Weight: _____ LB/KG %ILE _____ | |
| Physical Examination | <input checked="" type="checkbox"/> 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)
 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 |