

MEDICAL RECORD FOR ALL CHILDREN IN CHILD CARE FACILITIES

Parents are to complete the medical record side of this form for each child in registered or licensed child care facilities.

Child's Name _____ Date of Birth _____ Gender _____
First *Last*

Mother/Guardian Name _____ Home Address _____ <i>Street</i> <i>City</i> <i>Zip</i> Home Phone # _____ Work Address _____ <i>Street</i> <i>City</i> <i>Zip</i> Work Phone # _____	Father/Guardian Name _____ Home Address _____ <i>Street</i> <i>City</i> <i>Zip</i> Home Phone # _____ Work Address _____ <i>Street</i> <i>City</i> <i>Zip</i> Work Phone # _____
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Family Physician _____ Phone Number _____

Hospital Preference (for emergencies) _____

1. Has your physician approved the use of any non-prescription medications for you child such as acetaminophen, cough syrup, or ointments, that can be given by the day care provider? _____ No _____ Yes, as follows _____

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

_____ Allergies _____ Frequent Sore Throats/Colds _____ Ear Aches
 _____ Skin Problems _____ Other _____

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

3. Have there been any major changes at home that might affect you child in care? _____ No _____ Yes, as follows: _____

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

5. Please give dates for **ALL** immunization series completed by your child in the space below. Record MM/DD/YY.

		1	2	3	4	5
	DPT,DT*,TD (DT only if child is allergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO	/ /	/ /	/ /	/ /	
	MMR	/ /	/ /			
Single	RUBEOLA (MEASLES)	/ /	/ /			
Dose	MUMPS	/ /	/ /			
Only	RUBELLA (GERMAN MEASLES)	/ /	/ /			
	HIB (Hemophilus Influ. B) *RECOMMENDED	/ /	/ /	/ /	/ /	
	HAV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /				

CHILD HEALTH ASSESSMENT

The Child Health Assessment is to be completed and signed by a nurse approved by KDHE to perform Child Health Assessments or by 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.

PAST HEALTH HISTORY (DEVELOPMENTAL - ILLNESS - HOSPITALIZATION):

ALLERGIES _____

CURRENT MEDICATIONS _____

NUTRITIONAL STATUS _____

PHYSICAL EXAMINATION:

HEIGHT = _____ BMI % = _____ WEIGHT = _____

HEAD = _____

ABDOMEN = _____

EENT = _____

GU = _____

TEETH = _____

GYN = _____

HEART = _____

SKELETAL = _____

LUNGS = _____

NEUROLOGICAL = _____

SCREENING TESTS (DATES DONE AND RESULTS):

VISION = _____

TBC. TEST = _____

HEARING = _____

SICKLE CELL = _____

SPEECH = _____

HGB. (up to age 1) = _____

DDST = _____

U.A. (age 5yrs to 15yrs) = _____

LEAD = _____

BP = _____

OTHER = _____

DIAGNOSIS:

RECOMMENDATION:

DO YOU SEE THIS CHILD FOR REGULAR HEALTH SUPERVISION: YES NO

Signature of Licensed Physician or Nurse Approved for Child Health Assessments

Date (MM/DD/YYYY)

Print the Name of the Individual Signing Above

Phone Number

Address of Physician or Nurse

City

Zip Code

THE REVERSE SIDE OF THIS FORM MUST BE COMPLETED FOR EACH CHILD.

PARENTS MAY TRANSFER THIS FORM WHEN THEIR CHILD MOVES TO ANOTHER REGULATED CHILD CARE FACILITY IN KANSAS.