Appendix 6

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:	**Father/Guardian Name:**
_____	_____
Home Address:	Home Address:
_____	_____
Street City Zip	Street City Zip
Work Address:	Work Address:
_____	_____
Street City Zip	Street City Zip
Work Phone #:	Work Phone #:
_____	_____

Family Physician_____ 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 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 _____Ear Aches

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

   _____

3. Have there been any changes at home that might affect your child in care? _____ No _____Yes

   As follows: _____

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

   _____

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

		1	2	3	4	5
	Diphtheria, Tetanus, Pertussis (DTaP)	/ /	/ /	/ /	/ /	/ /
	POLIO (Poliomyelitis-IPV/OPV)	/ /	/ /	/ /	/ /	
	MMR (Measles, Mumps, Rubella)	/ /	/ /			
Single	Hepatitis B (HepB)	/ /	/ /			
Dose	Varicella (VAR)	/ /	/ /			
Only	Hemophilus Influenzae Type B (Hib)	/ /	/ /	/ /	/ /	
	Pneumococcal Conjugate (PCV)	/ /	/ /	/ /	/ /	
	Hepatitis A (HepA)	/ /	/ /			
	Rotavirus **Recommended <8 mo. of age	/ /	/ /	/ /		
	Influenza (Flu) **Rec.>5 mo. of age	/ /	/ /	/ /	/ /	/ /

Appendix 6

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.

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