CCL. 029
Rev. 02/2026

Kansas Department of Health and Environment
Curtis State Office Building
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270 | Fax 785-559-4244
Email: kdhe.cclr@ks.gov | kdhe.ks.gov/280/Child-Care-Licensing

Kansas Department of Health and Environment

Medical Record

Medical History

In accordance with K.A.R. 28-4-117 and K.A.R. 28-4-430, a completed medical record shall be on file at the facility for each child. For a Family Child Care Home, a completed medical record shall be on file for each child under 10 years of age enrolled for care and for each child under 16 years of age living in the child care facility. The medical record shall include a medical history, a record of current immunizations and a child health assessment. The medical record is 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

Name_____

Home Address_____
Street City Zip Code

Home/Cell Phone Number_____

Work Phone Number_____

E-mail Address_____

Best way to contact_____

Parent/Guardian Information

Name_____

Home Address_____
Street City Zip Code

Home/Cell Phone Number_____

Work Phone Number_____

E-mail Address_____

Best way to contact_____

Persons authorized to pick up the child or to notify in case of emergency (other than the parents):

Name _____ Name _____

Address _____ Address _____

Phone Number _____ Phone Number _____

Child's Physician_____ Phone Number_____

Hospital Preference (for emergencies)_____

Any known allergies or medical conditions of child: _____

_____

Any major changes at home that might affect your child in care: _____

_____

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

_____

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

Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____
Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____
Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____
Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____

Medical Record

Medical History (continued) - Immunizations

Child's Name: _____ Date of Birth: _____
First Last MM/DD/YYYY

Immunizations for each child in care shall be current as medically appropriate and shall be maintained current for protection from the diseases specified in K.A.R. 28-1-20(d).
A Kansas Certificate of Immunizations (KCI) may be substituted for this form and attached to the completed Medical Record.

Vaccine	Record the date (MM/DD/YY) each dose of vaccine was received				
	1st	2nd	3rd	4th	5th
Diphtheria, Tetanus, Pertussis (DTaP)					
Haemophilus influenzae type b (Hib)					
Hepatitis A (Hep A)					
Hepatitis B (Hep B)					
Measles, Mumps, Rubella (MMR)					
Pneumococcal disease (PCV15, PCV20)					
Poliomyelitis (IPV)					
Varicella (VAR)					
Respiratory syncytial virus (RSV) – Recommended, not required					
Rotavirus (RV) – Recommended, not required					
Influenza – Recommended, not required					

I attest that to the best of my knowledge the immunization information entered is true and correct.

Parent/Guardian Signature: _____ Date: _____

If your child is exempted from the law requiring immunizations, K.S.A. 65-508(g), check either (A) or (B) below and complete as required.

☐ (A) Certification from licensed physician stating that immunization would endanger the child's life. Child is exempt from the following immunizations:

_____DTaP _____Hib ____Hep A ____Hep B ____MMR ____PCV15/PCV20 ____IPV ____VAR

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.

Parent/Guardian Signature: _____ Date: _____

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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 another outlined acceptable form, is required for all children including children of the provider or staff in Family Child Care Homes, Child Care Centers and Preschools. Acceptable forms include: A Kan-Be-Healthy Assessment Form (KDHE Form), a Physician Health Assessment Form and a School Health Assessment Form 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): ☐ 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 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