



Complete Form Entirely
Write NA for Non-Applicable Items

**MEDICAL RECORD FOR ALL CHILDREN IN CHILD CARE FACILITIES,
INCLUDING PROVIDER'S OWN CHILDREN**

Parents are to complete the Medical Record and the History of Immunizations for each child in 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.

Child's First Day in Child Care _____

Name of Child Care Facility Happy Day Academy

Child's Name _____

Date of Birth _____ Gender _____

First Last

MM/DD/YYYY

M/F

Parent/Guardian Information

Parent/Guardian Information

Name _____

Name _____

Home Address _____

Home Address _____

Street City Zip Code

Street City Zip Code

Home Phone Number _____

Home Phone Number _____

Work Address _____

Work Address _____

Street City Zip Code

Street City Zip Code

Work Phone Number _____

Work Phone Number _____

Cell Phone Number _____

Cell Phone Number _____

E-mail Address _____

E-mail Address _____

Best way to contact _____

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) _____

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:

Does your child have any of the following conditions (yes or no)? If yes, provide information on Authorization for Emergency Medical Care form CCL. 010.

- | | | |
|--|--|------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Frequent sore throats/colds | <input type="checkbox"/> Ear Aches |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Speech, Visual, Hearing | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Other _____ | |

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

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

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

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

You may attach a printed shot record from your doctor's office. Must still sign & date form.

UPDATE AS SHOTS ARE ADMINISTERED

History of 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 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 law requiring immunizations [K.S.A. 65-508(d)].

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 ____HepA ____HepB ____Hib
 ____PCV ____Varicella ____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:** _____

