



**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 09/07/2022

Name of Child Care Facility New Creation Preschool #21910

Child's Name \_\_\_\_\_  
First Last

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_  
MM/DD/YYYY M/F

**Parent/Guardian Information**

**Parent/Guardian Information**

Name \_\_\_\_\_

Name \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City Zip Code

Home Address \_\_\_\_\_  
Street City Zip Code

Home Phone Number \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

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 \_\_\_\_\_

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

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Number \_\_\_\_\_

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Number \_\_\_\_\_

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: \_\_\_\_\_

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:** \_\_\_\_\_

## 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 <sup>st</sup>   | 2 <sup>nd</sup> | 3 <sup>rd</sup>                       | 4 <sup>th</sup> | 5 <sup>th</sup>  | 6 <sup>th</sup> |
| <b>Diphtheria, Tetanus, Pertussis (DTaP)</b>                             |   |                 |                                       |                 |                  |                 |
| <b>Poliomyelitis (IPV/OPV)</b>   |   |                 |                                       |                 |                  |                 |
| <b>Measles, Mumps, Rubella (MMR)</b>                                     |   |                 |                                       |                 |                  |                 |
| <b>Hepatitis B (HepB)</b>  |   |                 |                                       |                 |                  |                 |
| <b>Varicella (VAR)</b>   |   |                 | Hx of Disease:<br>Physician Signature |                 | Date of Illness: |                 |
| <b>Hemophilus Influenzae Type B (Hib)</b>                                |   |                 |                                       |                 |                  |                 |
| <b>Pneumococcal Conjugate (PCV)</b>                                      |   |                 |                                       |                 |                  |                 |
| <b>Hepatitis A (HepA)</b>  |   |                 |                                       |                 |                  |                 |
| <b>Rotavirus</b> **Recommended <8 mo of age; not required                |   |                 |                                       |                 |                  |                 |
| <b>Influenza(Flu)</b> ** 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(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    \_\_\_\_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:** \_\_\_\_\_

