CCL. 358
Rev. 5/2020

Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: (785) 296-1270 Fax (785) 559-4244
Website: www.kdheks.gov/kidsnet

HEALTH HISTORY FOR CHILDREN AND YOUTH ATTENDING SCHOOL AGE PROGRAMS

As required by K.A.R. 28-4-590(d) (1), each operator shall obtain a health history for each child or youth, on a form supplied by the department or approved by the secretary. Each health history is to be maintained in the child's or youth's file on the premises. As required by K.A.R. 28-4-590(d)(2), each operator shall require that each child or youth attending the program has current immunizations as specified in K.A.R. 28-1-20 or has an exemption for religious or medical reasons.

Complete one form for each child or youth attending the School Age Program.

First and Last Name of the Child or Youth	Gender (M or F)	Date of Birth (MM/DD/YYYY)	First day at this program: (MM/DD/YYYY)

First and Last Name of the Child's or Youth's Mother or Guardian

Mother/Guardian's Home Street Address	City	Zip Code	Home Phone # ( )

Mother/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ( )

First and Last Name of the Child's or Youth's Father or Guardian

Father/Guardian's Home Street Address	City	Zip Code	Home Phone # ( )

Father/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ( )

Names and ages of other children in the Child or Youth's Family (Attach additional page if needed.)

Person(s) authorized to pick up the Child or Youth in case of emergency. Include first and last name and Street Address. Attach additional page if needed.	City	Zip Code	Phone Number (during program hours):
1.			
2.			
3.			

First and Last Name of Physician & Street Address	City	Zip Code	Phone Number ( )

Name of Hospital Preference in case of emergency.

Yes	No	N/A	Complete the following information about medications for this child or youth.
			Will this child or youth need to take any nonprescription or prescription medication during their time at the program?
			If yes above, is there signed permission on file?

Circle any of the following conditions or difficulties that affect this child or youth.			
☐ Allergies	☐ Frequent sore throats/ colds	☐ Ear Infections or Aches	☐ Heart or Lung Conditions
☐ Skin Problems	☐ Asthma	☐ Headaches	☐ Diabetes
☐ Vision	☐ Speech/Communication	☐ Hearing	☐ Emotion/Behavior
Other: Please describe.			

If you circled any of the above conditions, please provide additional information that will help the staff members meet the child's or youth's needs while attending the program. (Attach additional page, if needed.)

Provide additional information about your child or youth that might affect him/her while at the School Age Program including any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.

Complete the following information about this child's or youth's immunization status.

Yes	No	
		Did this child or youth attend a public or accredited non-public school in Kansas, Missouri or Oklahoma the previous year?
		If yes, are this child's or youth's immunizations current?
X	X	**If yes to both of these questions, you do NOT need to complete the immunization history below. If no to either of the above questions, you must complete the immunization history below for this child or youth or attach a copy of the child's or youth's immunization history.**

Please give dates in the space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.

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

Print the First and Last Name of the Person Completing this Health History form	Relationship to the Child/Youth	Date Completed

If the Health History form was completed by a person other than a Parent/Guardian, who provided you with this information?	What is that person's relationship to the child/youth?

I attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct.

Signature of person completing this form	Date Signed

CCL 010
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Spanish

Departamento de Salud y Medio Ambiente de Kansas

Oficina de Salud Familiar
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Programa de Guarderías: 785-296-1270 Fax: 785-559-4244
Página Web: www.kdheks.gov/kidsnet

Kansas Department of Health and Environment

AUTORIZACIÓN PARA CUIDADO MÉDICO DE EMERGENCIA

Para tratamiento médico de emergencia se debe contar con un permiso por escrito archivado en la guardería. Consulte con el servicio médico de emergencia local para asegurarse de que este formulario sea aceptable. Referencia Reglamento de Guarderías K.A.R. 28-4-127(b)(1)(A). Referencia Reglamento de Guarderías para Programas de Edad Escolar K.A.R. 28-4-582(e)(2).

Nombre exacto de la guardería, tal como figura en la licencia.	**Licencia #**

Autorizo a JCPRD ________________ (proveedor de cuidados/miembro del personal), que es/son representante(s) de la guardería mencionada en la parte superior para dar consentimiento a todo y cualquier cuidado médico de emergencia que sea necesario para mi niño o joven ________________ (*nombre y apellido del niño*) mientras el niño o joven se encuentre en custodia de la guardería, entre ________________ y hasta que se termine la atención.

mes/día/año mes/día/año

¿Tiene el niño cobertura de seguro de salud? ☐ **Sí** ☐ **No**

Si lo tiene, llene lo siguiente:

Nombre de la póliza de seguro de salud ________________ Número de la póliza ________________

Programa de asistencia médica ________________ Número de tarjeta ________________

Número de identificación de tarjeta médica militar ________________

Si lo sabe, fecha de la última vacuna contra el Tétanos: ________________
mes/día/año

Enumere todas las alergias conocidas u otra información acerca de las condiciones médicas de este niño o joven, que sean pertinentes en caso de emergencia:

____

____

____

Firma del padre o tutor	**Fecha de la firma**

Testigo de la firma del padre o tutor, si así lo requiere el hospital o la clínica local.	**Fecha de la firma**

Notarización de la firma del padre o tutor, si así lo requiere el hospital o la clínica local.

Estado de Kansas

Condado de ________________

Firmado en mi presencia en esta fecha ________________ por ________________
mes/día/año Nombre de la persona

(Sello, si lo hubiera)

____
Firma del notario público

____
Título (y rango)

Mi designación termina en: ________________

- -

El formulario de evaluación/registro médico (o historial de salud de los Programas de Edad Escolar) y la autorización para cuidado médico de emergencia tienen que llevarse a la sala de emergencias. Ambos formularios también tienen que estar en el vehículo cuando la guardería transporte al niño o joven.