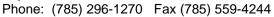
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Kansas Department of Health and Environment

Bureau of Family Health Child Care Licensing Program 1000 SW Jackson, Suite 200 Topeka, KS 66612-1274



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.

Comp	lete on	e form	for each child or youth attending	the Schoo	l Age Progi	ram.	
First a	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 a	and Las	t Name	of the Child's or Youth's Mother or G	uardian			
Mothe	er/Guaro	dian's H	lome Street Address	City		Zip Code	Home Phone #
Mothe	er/Guard	dian's W	Vork Place Name & Street Address	City		Zip Code	Work Phone #
First a	and Las	t Name	of the Child's or Youth's Father or G	uardian			
Fathe	r/Guard	ian's H	ome Street Address	City		Zip Code	Home Phone #
Father/Guardian's Work Place Name & Street Address			City Zip		Zip Code	Work Phone #	
Name	s and a	ges of c	other children in the Child or Youth's	Family (Atta	ch additiona	Il page if needed	.)
case o	of emer	gency.	I to pick up the Child or Youth in Include first and last name and ach additional page if needed.	City		Zip Code	Phone Number (during program hours):
2. 3.							
First and Last Name of Physician & Street Address			City		Zip Code	Phone Number ()	
Name	of Hos	pital Pre	eference in case of emergency.				
Yes	No	N/A	Complete the following information	about med	ications for t	his child or yout	h.
			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?

Allergies	Frequent sore throats/ colds	Ear Infections or Aches	Heart or Lung Conditions
Skin Problems	Asthma	Headaches	Diabetes
Vision	Speech/Communication	Hearing	Emotion/Behavior
	above conditions, please provide ad s while attending the program. (Attac		elp the staff members meet th

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

page, if needed.

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?
		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	1 1	/ /	/ /	/ /	,
	MMR	1 1	/ /		<u>. </u>	1
Single	RUBEOLA (MEASLES)	/ /	/ /			
Dose						
Only						
	MUMPS	/ /	/ /			
	RUBELLA (GERMAN MEASLES)	/ /	/ /			
L	HIB (Hemophilus Influ. B) *RECOMMENDED	1 1	/ /	/ /	/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		1
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /		<u> </u>	Ц	
	<u> </u>					

who provided you with this information? the child/youth?	If the Health History form was completed by a person other than a Parent/Guardian, who provided you with this information?	erson's relationship to 1?

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

	, <u>, , , , , , , , , , , , , , , , , , </u>	
Signature of person completing this form		Date Signed