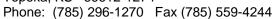
CCL. 358 Rev. 5/2020

## Kansas Department of Health and Environment

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



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		ram.		
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) 01/01/2024	
First and Last Name of the Child's or Youth's Mother or G	Guardian				
Mother/Guardian's Home Street Address	City		7in Codo	Home Phone #	
Mother/Guardian's nome Street Address	City		Zip Code	( )	
Mother/Guardian's Work Place Name & Street Address	City		Zip Code	Work Phone #	
monor/odd/ddd/o Work Flago Hamo & Gloot Addrood	Only .		Lip Code	( )	
First and Last Name of the Child's or Youth's Father or G	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 (Attacr	i additiona	ıı page ır needed	.)	
Person(s) authorized to pick up the Child or Youth in case of emergency. Include first and last name and	City		Zip Code	Phone Number (during	
Street Address. Attach additional page if needed.				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.					
rame of risophar releasing in case of cine geney.					
Yes No N/A Complete the following information	n about medica	tions for t	his child or yout	h.	
Will this child or youth need to take ar program?		on or preso	cription medication	n during their time at the	
If yes above, is there signed permission	ion on file?				
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Allergie								
	<b>2</b>	Frequent sore	e throats/ colds	Ear Infectio	ns or Ach	es H	eart or Lu	ng Conditions
Skin Pro	oblems	Asthma		Headaches		D	iabetes	
Vision		Speech/Comr	nunication _	Hearing		E	motion/Be	ehavior
Other: F	Please describe.							
If you c	ircled any of the a	above conditions,	please provide ad	ditional inform	ation that	t will help the	e staff me	mbers meet the
		while attending the						
includin		nation about your o						
Complete t	the following info	rmation about this	child's or youth's	s immunizatior	ı status.			
		child or youth atte	end a public or ac	credited non-p	ublic sch	ool in Kansa	s, Missou	ri or Oklahoma
		re this child's or ye	outh's immunizat	ions current?				
	If no to e	both of these que either of the above r attach a copy of t	questions, you n	nust complete	the immu	nization hist		
Please giv	e dates in the spa	ce below for ALL i	mmunization ser	ies completed			Record I	
				1	2	3	4	5
	DPT, DT*, TD (*[	DT only if child is all	ergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO			/ /	/ /	/ /	/ /	
						-	==	
	MMR			/ /	/ /			<del>_</del>
Single	MMR RUBEOLA (MEA	(SLES)		/ /	/ /			
Single Dose	<u> </u>	(SLES)						_
	RUBEOLA (MEA	SLES)		/ /	/ /			
Dose	RUBEOLA (MEA							
Dose	RUBEOLA (MEA  MUMPS  RUBELLA (GER	MAN MEASLES)	MMENDED	/ /			<b>1</b>	
Dose	RUBEOLA (MEA  MUMPS  RUBELLA (GERI  HIB (Hemophilus	MAN MEASLES) s Influ. B) *RECO	MMENDED	/ /			//	
Dose	RUBEOLA (MEA  MUMPS  RUBELLA (GERI  HIB (Hemophilus  HBV (Hepatitis B	MAN MEASLES) s Influ. B) *RECO 3 Vaccine) *RECO	MMENDED				/ /	
Dose	RUBEOLA (MEA  MUMPS  RUBELLA (GERI  HIB (Hemophilus  HBV (Hepatitis B	MAN MEASLES) s Influ. B) *RECO	MMENDED	/ /			/ /	
Dose Only	MUMPS RUBELLA (GERI HIB (Hemophilus HBV (Hepatitis B	MAN MEASLES) s Influ. B) *RECO 3 Vaccine) *RECO	OMMENDED  OMMENDED				p to the	Date Completed
Dose Only  Print the	RUBEOLA (MEA  MUMPS  RUBELLA (GERI  HIB (Hemophilus  HBV (Hepatitis B  VAR (Varicella-C	MAN MEASLES) s Influ. B) *RECO Vaccine) *RECO Chicken Pox) *RECO ame of the Person was completed by	OMMENDED  Completing this	/ / / / / / / / Health History	/ / / / / / / / / / / / / / / / / / /	/ / Relationshi Child/Youth	p to the	Date Completed