



AUTHORIZATION FOR EMERGENCY MEDICAL CARE

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A). School Age Programs reference K.A.R. 28-4-582(e)(2).

Name of facility exactly as stated on the license.	License #
Kiddy Kollege Child Care Center	70347 501121

I hereby authorize Erika Tomlin (Name of individual/staff member) and/or Any Kiddy Kollege Staff or Volunteer (Name of individual/staff member) who is (are) representative(s) of the above named facility to give consent for any and all necessary emergency medical care for my child or youth _____ X (First and Last Name of Child or Youth) while said child or youth is in said facility's custody between the dates of X and Termination of Care.
MM/DD/YYYY MM/DD/YYYY

Signature of Parent or Guardian	Date Signed
<u>X</u>	

Witness to Parent's or Guardian's signature if required by the local hospital or clinic.	Date Signed
<u>X</u>	

Notarization of Parent's or Guardian's signature if required by local hospital or clinic.

State of <u>Kansas</u> County of _____
Signed or attested before me on _____ by _____. MM/DD/YYYY Name of Person
(Seal, if any.)
_____ Signature of notarial officer
_____ Title (and Rank)
My appointment expires: _____

List any known allergies or other information about the medical status of this child or youth pertinent in case of emergency:

Is child covered by health insurance? Yes No **MUST PROVIDE INSURANCE INFO!**

If yes, complete the following:

Health Insurance Policy Name _____ Policy Number _____
 Medical Assistance Program _____ Card Number _____
 Military Medical Care I.D. Number _____

If known, date of last Tetanus inoculation: _____

THE MEDICAL RECORD/ASSESSMENT FORM (OR HEALTH STATUS HISTORY FORM FOR SCHOOL AGE PROGRAMS) AND THE AUTHORIZATION FOR EMERGENCY MEDICAL CARE MUST BE TAKEN TO THE EMERGENCY ROOM. BOTH FORMS MUST ALSO BE IN A VEHICLE WHEN THE CHILD OR YOUTH IS TRANSPORTED BY THE FACILITY.



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 Kiddy Kollege LLC

Child's Name _____
First Last

Date of Birth _____ Gender _____
MM/DD/YYYY M/F

Parent/Guardian Information

Name _____

Parent/Guardian Information

Name _____

Home Address _____
Street City Zip Code

Home Address _____
Street City Zip Code

Home Phone Number _____

Home Phone Number _____

Work Address _____
Street City Zip Code

Work Address _____
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.

- | | | |
|-------------------------|-----------------------------------|-----------------|
| _____ Allergies | _____ Frequent sore throats/colds | _____ Ear Aches |
| _____ Asthma | _____ Speech, Visual, Hearing | _____ Diabetes |
| _____ Epilepsy/Seizures | _____ 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 printed shot record from your

Doctor's Office. Must still Sign & Date

History of Immunizations

UPDATE AS SHOTS ARE ADMINISTERED

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: _____

**Must be completed by
Doctor or Nurse
Within 6 months of care**

Child Health Assessment

The Child Health Assessment form is to be completed and signed by a nurse approved by KDHE to perform Child Health Assessments or a Licensed Physician. If a Physician Assistant (PA) completes the Child Health Assessment, the signature of the Licensed Physician authorizing the PA is to be included at the bottom of this form.

A Child Health Assessment, recorded on a KDHE Form or other acceptable Forms mentioned below, is required for all children including children of the provider or staff in Licensed Day Care Homes, Group Day Care Homes, Child Care Centers and Preschools. A Kan-Be-Healthy Assessment Form is a KDHE Form and is acceptable, a Physician Health Assessment Form is acceptable, and a School Health Assessment Form is acceptable for school-age children or youth. The Health Assessment Form used should be attached to the KDHE Medical Record Form (CCL. 029).

Child's Name _____ **Date of Birth** _____
First Last

Health history and medical information pertinent to routine child care and emergencies (describe, if any): <input type="checkbox"/> None	Do you see this child for regular health supervision: <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to food or medicine (describe, if any): <input type="checkbox"/> None	
List current medications (if any): <input type="checkbox"/> None	

Length/Height: _____ IN/CM %ILE _____		Weight: _____ LB/KB %ILE _____	
Physical Examination		<input checked="" type="checkbox"/> If Normal	If Abnormal - Comments
Head/Ears/Eyes/Nose/Throat			
Teeth			
Cardio/Respiratory			
Abdomen/GI			
Genitalia/Breasts			
Extremities/Joints/Back/Chest			
Skin/Lymph Nodes			
Neurologic & Developmental			
Screening Tests		Screening Date	Note Here if Results are Pending or Abnormal
Lead			
Anemia (HGB/HCT)			
Urinalysis (UA)			
Hearing			
Vision			
Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (Attach additional sheets if necessary) <input type="checkbox"/> None			
Signature of Licensed Physician or Nurse approved for Child Health Assessments			Date
Print the Name of the Individual Signing Above			Phone Number
Address		City	Zip Code