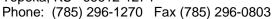
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Kansas Department of Health and Environment

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.

Compl	lete on	e form	for each child or youth attending	the School	ol Age Prog	ram.	
First a	and Las	t 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			
				Lau		T=: a :	111 51 "
Mothe	er/Guard	dian's H	Iome Street Address	City		Zip Code	Home Phone #
Mother/Guardian's Work 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 Code	Work Phone #	
						1	-
Name	s and a	ges of c	other children in the Child or Youth's	Family (Att	ach additiona	al page if needed	.)
Porco	n/s) au	horizoa	to nick up the Child or Youth in	City		Zip Code	Phone Number (during
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	program hours):	
1.							
2.							
3.							
Firet a	and I as	t Name	of Physician & Street Address	City		Zip Code	Phone Number
111300	illa Las	· Hame	or riyalolari a otreet Address	Oity		Zip couc	()
Name	of Hos	pital Pro	eference in case of emergency.				
V- :	l NI	N1/4	Onwellete the fall to the fall	-1	li	Lia aliila	L
Yes	No	N/A	Complete the following information	about med	lications for f	inis child or yout	n.
			Will this child or youth need to take an program?	ny nonpresc	ription or pres	cription medication	n during their time at the

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
Other: Please describ	e.		

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?
		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	/ /	/ /		<u>:</u>	u
Single	RUBEOLA (MEASLES)	/ /	/ /			
Dose						
Only						
	MUMPS	/ /	/ /			
	RUBELLA (GERMAN MEASLES)	/ /	/ /			
<u> </u>	HIB (Hemophilus Influ. B) *RECOMMENDED	/ /	/ /	/ /	/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		Ц
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /		<u> </u>	Ц	
		[]	ll .			

	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'the child/youth?	s relationship to

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**