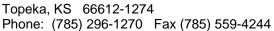
CCL. 358 Rev. 5/2020

## 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.

| Comp   | lete or  | ne form   | for each child or youth attending  | the School                                   | I Age Prog         | ram.                          |  |  |
|--|----------|-----------|--|--|--------------------|-------------------------------|--|--|
| First  | and La   | st Name   | of the Child or Youth  |  | Gender<br>(M or F) | Date of Birth<br>(MM/DD/YYYY) | First day at this program:<br>(MM/DD/YYYY) |  |
| First  | and La   | st Name   | of the Child's or Youth's Mother or G  | Guardian                                     |                    |                               |  |  |
| Moth   | er/Guai  | rdian's F | Home Street Address  | City   |                    | Zip Code                      | Home Phone #                               |  |
| Moth   | er/Guai  | rdian's V | Nork Place Name & Street Address   | City   |                    | Zip Code                      | Work Phone #                               |  |
| Final  |          | at Nama   | of the Children Vouth's Fother or C  |  |                    |                               | ( )  |  |
| rirst  | and La   | st Name   | of the Child's or Youth's Father or G  | uardian                                      |                    |                               |  |  |
| Fathe  | er/Guar  | dian's H  | ome Street Address   | City   |                    | Zip Code                      | Home Phone #                               |  |
| Fathe  | er/Guar  | dian's W  | Vork Place Name & Street Address   | City   |                    | Zip Code                      | Work Phone #                               |  |
| Name   | es and a | ages of o | other children in the Child or Youth's   | Family (Atta                                 | ach additiona      | al 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.<br>2.   |          |           |  |  |                    |                               |  |  |
| 3.   |          |           |  |  |                    |                               |  |  |
| First  | and La   | st Name   | of Physician & Street Address  | City   |                    | Zip Code                      | Phone Number                               |  |
| Name   | of Hos   | spital Pr | eference in case of emergency.   |  |                    |                               |  |  |
|  |          |           |  |  |                    |                               |  |  |
| Yes  | No       | N/A       | Complete the following information   | n 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?  |  |                    |                               |  |  |

| Asthma Headaches Diabetes  Provide additional information about your child or youth that might affect him/her while at the School Age Program neluding any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.)  Provide additional information about your child or youth that might affect him/her while at the School Age Program neluding any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.  Provide additional information about this child's or youth's immunization status.  (es 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.    Single   RUBEOLA (MEASLES)  | Circle a      | any of the   | e following c  | onditions or difficulties that affe | ct this child or      | youth. IF  | IT DOES NO    | OT APPLY,                | PUT "N/A"          |
|--|---------------|--|----------------|-------------------------------------|-----------------------|------------|---------------|--------------------------|--------------------|
| Speech/Communication Hearing Emotion/Behavior  Sher: Please describe.  Flyou circled any of the above conditions, please provide additional information that will help the staff members meet the hild'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 natural gard and special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.)  Provide additional information about your child or youth's immunization status.  The provide additional information about this child's or youth's immunization status.  The provide additional information about this child's or youth's immunization status.  The provide additional information about this child's or youth's immunization status.  The provide additional information about this child's or youth's immunization status.  The provide additional information about this child's or youth's immunization status.  The provide additional information activities and information activ | Allergies     |  |                | Frequent sore throats/ colds        | Ear Infections or Ach |            | nes l         | Heart or Lung Conditions |                    |
| Tyou 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 necluding any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.)  In plote the following information about this child's or youth's immunization status.  The previous year?  If yes, are this child's or youth's immunization scurrent?  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.  The segive dates in the space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.  DPT, DT*, TD ("DT only if child is allergic to DTP)  POLIO  MMR  If you have the child or youth allergic to DTP)  WIMMR  If you have the child or youth. Record MM/DD/YYYY.  The Hilb (Hemophilus Influ. B) "RECOMMENDED   / / / / / / / / / / / / / / / / / /   | Skin Problems |  |                | Asthma                              | Headaches             |            |               | Diabetes                 |                    |
| ry ou circled any of the above conditions, please provide additional information that will help the staff members meet the thild'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 netuding any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.)  In plete the following information about this child's or youth's immunization status.  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.  If yes to both of these 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.  If yes to both of these questions, you must completed the immunization history below for this child or youth or attach a copy of the child's or youth's immunization history.  If yes to both of these questions, you must completed by this child or youth. Record MM/DD/YYYY.  If yes to both of these questions, you must completed by this child or youth. Record MM/DD/YYYY.  If yes poble for the above questions, you must completed by this child or youth. Record MM/DD/YYYY.  If yes to both of these questions, you must completed by in this child or youth. Record MM/DD/YYYY.  If yes to both of these questions, you must completed by in this child or youth. Record MM/DD/YYYY.  If yes to both of the sequestions, you must completed by internation history.  If yes, are this child or youth in this child or youth. Record MM/DD/YYYY.  If yes, are this child's or youth's immunization history.  If yes, are this child's or youth's immunization history.  If yes, are t | Vision        |  |                | Speech/Communication                | Hearing               |            | E             | motion/Be                | ehavior            |
| Provide additional information about your child or youth that might affect him/her while at the School Age Program neutuding any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional sage, if needed.    Provide additional needs, restrictions to activities, major changes at home or special instructions. (Attach additional sage, if needed.    It is not consider that the following information about this child's or youth's immunization status.    Provide additional needs, restrictions to activities, major changes at home or special instructions. (Attach additional sage, if needed.)    It is not consider that the following information about this child's or youth's immunization status.    Provide additional needs, restrictions to activities, major changes at home or special instructions. (Attach additional sage, if needed.)    Provide additional needs, restrictions to activities, major changes at home or special instructions. (Attach additional sage, if needed.)    Provide additional needs, restrictions to activities, major changes at home or special instructions. (Attach additional sage, if needed.)    Provide additional needs, restrictions to activities, major changes at home or special instructions. (Attach additional sage, if needed.)    Provide additional needs, restrictions to activities, major changes at home or special instructions. (Attach additional sage, if needed.)    Provide additional needs, restrictions to activities, major changes at home or special needs. (Attach additional sage, if needed.    Provide additional needs, restrictions to activities, major changes at home or special needs. (Attach additional sage, if needed.    Provide additional satus. (Attach additional satus.)    Provide additional satus. (Attach additional satus.)   Provide additional satus. (Attach additional satus.)   Provide additional satus. (Attach additional satus.)   Provide additional satus. (Attach additional satus.)   Provide additional satus. (Attach additional satus.) | Other:        | Please d   | escribe.       |                                     |                       |            |               |                          |                    |
| neluding any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.    Polity   Polit |               |  |                |                                     |                       |            |               | e staff me               | mbers meet the     |
| 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.  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. Record MM/DD/YYYY.  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 do NOT need to complete the immunization history below. If no to either of the above questions, you do NOT need to complete the immunization history below. If no to either of the above questions, you do NOT need to complete the immunization history below. If no to either of the above questions, you do NOT need to complete the immunization history below. If no to either of the All Date of the All Date of the All Date of the Person Completing this Health History form   Relationship to the Child/Youth   Date Complete Child/Youth   Date Complete the Health History form was completed by a person other than a Parent/Guardian,   What is that person's relationship to the child/youth?   | includi       | ng any s   | pecial needs   |                                     |                       |            |               |                          |                    |
| 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.  It is give dates in the space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.  It is give dates in the space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.  It is give dates in the space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.  It is give dates in the space below for ALL immunization series complete by this child or youth. Record MM/DD/YYYY.  It is give dates in the space below for ALL immunization series complete the immunization history below for this child or youth. Record MM/DD/YYYY.  It is to either of the above questions, you do NOT need to complete the immunization history below. Institute of the provided you with this information?  It is to either of the above questions, you do NOT need to complete the immunization history below. Institute the immunization history below. Institute of the child/youth.  It is to either of the above questions, you do NOT need to complete the immunization history below. Institute the immunization history. Institute the immunization history.  It is to either of the immunization history. Institute the immunization history. Insti | mplete<br>Yes |  | wing informa   | ation about this child's or youth's | s immunization        | n status.  |               |                          |                    |
| 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.  If yes to both of these questions, you must complete the immunization history youth or attach a copy of the child's or you must complete the immunization history below. If no to either of the above questions, you must complete the immunization history below. If no to either of the acoustic history form the immunization history below. If no to either of the acoustic history form and the immunization history below. If no to either or history form are the immunization history below. If no to either of the complete complete the immunization history below. If no to either of the complete complete the immunization history below for this child or youth. Record MMDD/YYYY.  If yes to both of the schild or youth fill or youth. Record MMDD/YYYY.  If youth or youth or attach a copy in the immunization history below for this child or youth. Record MMDD/YYYY.  If you had youth or youth or history below for this child or youth. Record MMDD/YYYY.  If you had youth or youth or history below for this child youth. If you his child youth?  If you had you with his information?  If you had you with his form is true and correct the immunization provided on this form is true and correct the immunization provided on this form is true and correct the immunization provided on this form is true and correct the immunization provided on this form is true and correct the immunization provided on this form is true and correct the immunization provided on this form is true and correct the immunization provided on this form is true and correct the immunization provided on this form is true and correct the immunization provided on this form is true and correct the immunization provided on this form is true and correct |               |  |                |                                     | credited non-p        | ublic sch  | ool in Kans   | as, Missou               | ri or Oklahoma     |
| 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.  It would be a space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.  It would be a space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.  It would be a space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.  It would be a space below for ALL immunization history.  It w |               |  |                |                                     | ions current?         |            |               |                          |                    |
| DPT, DT*, TD (*DT only if child is allergic to DTP)    DPT, DT*, TD (*DT only if child is allergic to DTP)   | $\times$      | If no to either of the above questions, you must complete the immunization history below for this child or |                |                                     |                       |            |               |                          |                    |
| DPT, DT*, TD (*DT only if child is allergic to DTP)  POLIO  // // // // //  MMR  // // //  RUBEOLA (MEASLES)  // //  RUBELLA (GERMAN MEASLES)  // //  HIB (Hemophilus Influ. B) *RECOMMENDED  HBV (Hepatitis B Vaccine) *RECOMMENDED  VAR (Varicella-Chicken Pox) *RECOMMENDED  // //  VAR (Varicella-Chicken Pox) *RECOMMENDED  //  Tint the First and Last Name of the Person Completing this Health History form  Relationship to the Child/Youth  The Health History form was completed by a person other than a Parent/Guardian, what is that person's relationship to the child/youth?  attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct  | ease giv      | ve dates   | in the space   | below for ALL immunization seri     | ies completed         | by this ch | nild or youth | . Record                 | MM/DD/YYYY.        |
| POLIO  MMR  MMR  MMR  MUBEOLA (MEASLES)  MUMPS  RUBELLA (GERMAN MEASLES)  MUMPS  RUBELLA (GERMAN MEASLES)  MIB (Hemophilus Influ. B) *RECOMMENDED  HBV (Hepatitis B Vaccine) *RECOMMENDED  VAR (Varicella-Chicken Pox) *RECOMMENDED  VAR (Varicella-Chicken Pox) *RECOMMENDED  Trint the First and Last Name of the Person Completing this Health History form  Relationship to the Child/Youth  The Health History form was completed by a person other than a Parent/Guardian, who provided you with this information?  attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct  |               |  |                |                                     | 1                     | 2          | 3             | 4                        | 5                  |
| MMR  |               | DPT, [   | DT*, TD (*DT   | only if child is allergic to DTP)   | / /                   | / /        | / /           | / /                      | / /                |
| Single RUBEOLA (MEASLES)    / / / /     MUMPS  |               | POLIC  | )              |                                     | / /                   | / /        | / /           | / /                      |                    |
| Only  MUMPS  RUBELLA (GERMAN MEASLES)  HIB (Hemophilus Influ. B) *RECOMMENDED / / / / / / / / / / / / / / / / / /  |               | MMR  |                |                                     | / /                   | / /        |               | <u> </u>                 | <u> </u>           |
| MUMPS  RUBELLA (GERMAN MEASLES)  HIB (Hemophilus Influ. B) *RECOMMENDED / / / / / / / / / / / / / / / / / /  | Single        | RUBE   | OLA (MEASL     | ES)                                 | / /                   | / /        |               |                          |                    |
| MUMPS  RUBELLA (GERMAN MEASLES)  HIB (Hemophilus Influ. B) *RECOMMENDED / / / / / / / / / / / / / / / / / /  | Dose          |  |                |                                     |                       |            |               |                          |                    |
| HIB (Hemophilus Influ. B) *RECOMMENDED / / / / / / / / / / / / / / / / / /   | Only          | MUMF   | PS             |                                     | / /                   | / /        |               |                          |                    |
| HBV (Hepatitis B Vaccine) *RECOMMENDED / / / / / / / / / / / / / / / / / /   |               | RUBE   | LLA (GERMA     | N MEASLES)                          | / /                   | / /        |               |                          |                    |
| VAR (Varicella-Chicken Pox) *RECOMMENDED / /  rint the First and Last Name of the Person Completing this Health History form Relationship to the Child/Youth  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?  attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct   |               | HIB (H   | emophilus Inf  | flu. B) *RECOMMENDED                | / /                   | / /        | / /           | / /                      |                    |
| rint the First and Last Name of the Person Completing this Health History form  Relationship to the Child/Youth  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?  attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct  |               | HBV (I   | Hepatitis B Va | accine) *RECOMMENDED                | / /                   | / /        | / /           |                          |                    |
| 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?  attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct   |               | VAR (  | √aricella-Chic | ken Pox) *RECOMMENDED               | / /                   |            |               |                          |                    |
| 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?  attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct   | Print th      | e First a  | nd Last Name   | of the Person Completing this       | Health History        | ⊒<br>form  | Relationsh    | in to the                | Date Completed     |
| the child/youth?  attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct  |               | ot al  | .s Edot Haille | 2 c 5.55 Completing this            |                       |            |               |                          | Sale Completed     |
|  |               |  |                |                                     | han a Parent/G        | uardian,   |               |                          | 's relationship to |
|  |               |  |                |                                     | rledge, the info      | rmation p  | provided on   |                          |                    |

CCL.010 Rev. 07/2024 Curtis State Office Building Kansas Department of Health and Environment 1000 SW Jackson, Suite 200 Topeka, KS 66612-1274

Phone: 785-296-1270 | Fax 785-559-4244

Email: kdhe.cclr@ks.gov | kdhe.ks.gov/ChildCareLicensing



## **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 Nelson Elementary SAP - #42718, Freeman Element | License #<br>-#61570                    |  |  |
|---|---|--|--|
| Oatville Elementary SAP - #42716 Rex Elementary   | SAP - #42719, Ruth Clark Elementary SAP | - #42917, Haysville Activity Center - #48593 |  |
|   |   | -  |  |
| I authorize   | uthorizeHRD & Staff Members             |  |  |
| is/are representative(s) of the above-name  |   |  |  |
| care for my child or youth  | (                                       | child's first and last name) while           |  |
| child or youth is in the facility's custody be  | etween08/13/25 and                      | 05/19/26                                     |  |
|   | MM/DD/YYYY                              | MM/DD/YYYY                                   |  |
| emergency:  |   |  |  |
|   |   |  |  |
| Signature of Parent or Guardian   |   | Date Signed                                  |  |
|   |   |  |  |
|   |   |  |  |

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 off premised from the facility.