



## Child Health History School Age Programs

In accordance with K.A.R. 28-4-590(d)(1), each school age program operator shall obtain a health history for each child or youth. Each health history shall be maintained in the child's or youth's file on the premises.

Child's First Day in Child Care \_\_\_\_\_ Name of Child Care Facility \_\_\_\_\_

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_  
First Last MM/DD/YYYY M/F

### Parent/Guardian Information

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Name _____	Name _____
Home Address _____ Street City Zip Code	Home Address _____ Street City Zip Code
Home/Cell Phone Number _____	Home/Cell Phone Number _____
Work Phone Number _____	Work Phone Number _____
E-mail Address _____	E-mail Address _____
Best way to contact _____	Best way to contact _____

Persons authorized to pick up the child or to notify in case of emergency (other than the parents):

Name _____	Name _____
Address _____	Address _____
Phone Number _____	Phone Number _____

Child's Physician Name & Phone Number \_\_\_\_\_

Physician Address \_\_\_\_\_

Hospital Preference (for emergencies): \_\_\_\_\_ Lawrence Memorial Hospital (nearest ER)

List any allergies or medical conditions of child:

\_\_\_\_\_

List any non-prescription or prescription medication the child will take during their time at the program:

\_\_\_\_\_

Provide additional information that will help staff meet the needs of the child (attach additional page if needed):

\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Child Health History (continued) Immunizations

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
First Last MM/DD/YYYY

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.

K.A.R. 28-4-590(d)(4) Children or youth who are currently attending or who attended in the preceding school year a public or accredited non-public school in Kansas, Missouri, or Oklahoma shall not be required to provide documentation of current immunizations or exemptions from immunizations.

**Do not provide immunization or exemption information if the child or youth is currently attending, or was attending during the previous school year at, a public or accredited non-public school.**

Vaccine	Record the date (MM/DD/YY) each dose of vaccine was received				
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	5 <sup>th</sup>
Diphtheria, Tetanus, Pertussis (DTaP)					
Haemophilus influenzae type b (Hib)					
Hepatitis A (Hep A)					
Hepatitis B (Hep B)					
Measles, Mumps, Rubella (MMR)					
Pneumococcal disease (PCV15, PCV20)					
Poliomyelitis (IPV)					
Varicella (VAR)					
Respiratory syncytial virus (RSV) – Recommended, not required					
Rotavirus (RV) – Recommended, not required					
Influenza – Recommended, not required					
I attest that to the best of my knowledge the immunization information entered is true and correct.					
Parent/Guardian Signature: _____ Date: _____					

If your child is exempted from the law requiring immunizations, K.S.A. 65-508(g), check either (A) or (B) below and complete as required.

(A) Certification from licensed physician stating that immunization would endanger the child's life. Child is exempt from the following immunizations:

\_\_\_\_ DTaP \_\_\_\_ Hib \_\_\_\_ Hep A \_\_\_\_ Hep B \_\_\_\_ MMR \_\_\_\_ PCV15/PCV20 \_\_\_\_ IPV \_\_\_\_ VAR

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.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_