CCL 053 Rev. 9/2003

## KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES 503 SOUTH KANSAS AVENUE, TOPEKA, KS 66603-3404 PHONE (785) 296-4986 FAX (785) 296-0256

## MEDICAL RECORD FOR CHILDREN IN 24 HOUR CARE FACILITIES

(School Health Form or the KAN Be Healthy Form May Be Used)

Name:	Birthdate:	Male/Female:	
Address:	City:		
Parent/Guardian:	Work Phone:	,	
Child lives with:	Work Phone:		
Number in household:	- 66		
,	Date of last examination:		
Dentist:	Date of last examination:		
Eye Doctor:	Community Services:		
School:			
FAMILY HEALTH HISTORY			
Response Codes: M = Maternal P = Paternal	S = Sibling	N/A = Not Applicable	
		Code Cor	nment
Are there any chronic illness problems in your family such as heart d	isease, diabetes,		
2. Does any family member have a vision defect, hearing loss or spinal of			
CHILD/ADOLESCENT HISTORY			
Response Codes: $Y = Yes$ $N = No$	N A = Not applicable		
Birth weight Were there any pre-natal or delivery proble	ems with the child?		
2. Did this child walk, talk and develop at the usual time?			
3. Does this child/adolescent:			
a. See a health care provider regularly?			
b. Use any medication, drugs or alcohol?			
c. Have a history of any hospitalizations, surgeries or emergency ro	om visits?		
d. Have a history of any childhood diseases/illnesses?			
e. Have a history of other communicable diseases?			
f. Age menarche Have a history of menstrual problems?			
g. Have a history of vision, speech, hearing or communication prob	olems?		
h. Have a problem with being tired or overactive?			
i. Have any emotional or behavioral problems?			
j. Need any special help in school or day care?			
k. Have sexuality concerns?			
I. Have any chronic illness or disabling problems with:			
Headache Convulsions Colds/sore throat Rheumatic fever Heart/lung disease Allergies/Asthma	Diabetes Earaches Genitalia Oral/dental Digestive Urinary/bowel	Back/spine/ extremity probl Other	ems
List present concerns of child/parent/guardian/fost er parent:			
and present concerns of crimo, parent, guardian, rost er parent.			

Immunization:	Record	date of	each dos	se receive	d (mm/dd/yy)		*Required	t	**Recomm	ended			
		1st	2nd	3rd	4th	5th				1st	2nd	3rd	4th
DPT (Diphtheria, per	tussis,							_					
tetanus)* Td/DT *			<del>                                     </del>	<del> </del>			MMR (Measles, Mu		ubella) *		<del> </del>		7
OPV or IPV (Polio) *		<del>                                     </del>	<del>                                     </del>	+		1	HBV (Hepatitis B) * TB (Skin Test) *			Date	Result		_
Immunization:		date of	each do	se receive	d (mm/dd/y	V)	*Required	1	**Recomm		nesuit		
PHYSICAL EXAMINA										criaca			
Height			Weig	-					Hgb or H	lct _			
Pulse				d Pressure le Cell	е				Lead Other	_			
Urinalysis Tuberculosis				ie Ceii d Circumfe	erence				Other	_			
	<del></del> -		rica	a Onodinie	5101100								
Code Each Item as	Follows:	Cod	de				Description of F	Findinas					
0 = No significar							_ = = = = = = = = = = = = = = = = = = =						
1 = Significant fi													
General Appearanc	Δ												
Integument	C												
Head - Neck													
EENT													
Oral - Dental													
Thorax													
Breasts													
Cardiovascular Abdomen													
Musculoskeletal													
Genitourinary													
Neurological													
SCREENING													
1. Nutritional Evaluati	on (all ages	- each sc	creen) (🗸	if applical	ble)		Nutrition/WIC Qu	estionna	ires availabl	e from (78	35) 296-00°	92.	
□ Enrolled	in WIC	∃ Receivi	ing Vitam	າin Supple	ment with i	ron 🗆	Without iron ☐ FI	luoride S	upplement				
Food intake review													
	s, eggs eals												
	pe of screer												
2. Development	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				Results								
3. Speech													
4. Hearing													
5. Vision					Results						en		
Significant Assessn	nent Findings	<u>3</u> :						Anticip	atory Guida	nce: (circl	e those dis	cussed)	
								1. Saf	ety/poisons	8.	Lifestyle	9. Devel	opment
								2. Nut			. Behavior		
									renting		. Sexuality		
									mily Planning		. Dental		
Pagammandations:	(include refe	arrolo)						5. Dis	cipline nunizations	13	. Other		
Recommendations:	(include rele	mais)						7. Hy					
								Comm					
								30					
Follow Up:													
								]					
Additional Information	n may be atta	iched											
Cianature of Line	l Dhuele!	w Ni		l +a	m he=!#!-								
Signature of Licensed assessments.	ı Priysician o	i inurse a	approved	i to perforr	m health Date								