First Baptist Christian Preschool

Child's Full Name: ______________________ Birthdate (mm/dd/yy): __________ Sex:____

Mother: ____

Home Address: ____

City: ______________________ State: ______________ Zip: __________

Home Phone: __________ Cell Phone: ___________ Work Number: ___________

E-mail: ____

Best way to contact: ____

Father: ____

Home Address: ____

City: ______________________ State: ______________ Zip: __________

Home Phone: __________ Cell Phone: ___________ Work Number: ___________

E-mail: ____

Best way to contact: ____

Siblings of child living in home (Names & Ages):

____

____

____

Others not mentioned above living in home (Names/Ages/Relationship):

____

____

Persons to Call for Emergencies (if parents cannot be reached):

Name: ___________________ Address: _______________ Phone: __________

Name: ___________________ Address: _______________ Phone: __________

Child's Medical Doctor: _________________ Address: __________ Phone: __________

Hospital Preference, if any: _______________ Address: __________ Phone: __________

Full names of persons authorized to take child from center. Child will not be released to any other persons unless parent notifies director or staff ahead of time.

____

____

Church affiliation or Denomination: ______________________________

Class choice: ______________________ Deposit: ______________________

CCL. 029
Rev.02/2009

Kansas Department of Health and Environment
Child Care Licensing and Registration Program
1000 SW Jackson, Suite 200, Topeka, KS 66612-1274
Phone: (785) 296-1270 Fax: (785) 296-0803
Website: www.kdheks.gov/bcclr/index.html

MEDICAL RECORD FOR ALL CHILDREN IN CHILD CARE FACILITIES AND FAMILY DAY CARE HOMES, INCLUDING PROVIDER'S OWN CHILDREN

Parents are to complete the Medical Record and the History of Immunizations for each child in registered family day care homes or 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 or family day care home.

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

Name______________________________
Home Address______________________________
Street City Zip Code
Home Phone Number______________________________
Work Address______________________________
Street City Zip Code
Work Phone Number______________________________
Cell Phone Number______________________________
E-mail Address______________________________
Best way to contact______________________________

Parent/Guardian Information

Name______________________________
Home Address______________________________
Street City Zip Code
Home Phone Number______________________________
Work Address______________________________
Street City Zip Code
Work Phone Number______________________________
Cell Phone Number______________________________
E-mail Address______________________________
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)______________________________

1. 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:

____

2. Does your child have any of the following conditions? Please answer yes or no.

______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______________________________

3. Have there been major changes at home that might affect your child in care? ____ No ____Yes, as follows:

____

4. Please provide additional information or special instructions that will help the person caring for your child.

____

Signature of Parent/Guardian______________________________ **Date:**____________

History of Immunizations

For all children in child care facilities and family day care homes, 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/Y

SECTION I.

Vaccine	Record the Month. Day and Year that each Dose of Vaccine was Received					
	1st	2nd	3rd	4th	5th	6th
DTaP/DT/Td/Tdap (Diphtheria, Tetanus, Pertussis)						
Polio						
MMR (Measles, Mumps, and Rubella combined)						
HBV (Hepatitis B Vaccine)						
Varicella (Chicken Pox)			Hx of Disease: Physician Signature		Date of Illness:	
HIB (Hemophilus Influenzae Type B)						
PCV7 (Pneumococcal Conjugate)						
HEP A (Hepatitis A)						
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 laws requiring immunizations [K.S.A. 65-508(d) and K.S.A. 65-519(c)].

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:

____DTP ____Pertussis Only ____Tetanus ____Polio ____MMR ____Rubella Only ____Hep A ____Hep B
Hib ____PCV7 ____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:**__________

Kansas Department of Health and Environment
Bureau of Family Health
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Child Care Program: (785) 296 -1270 Fax: (785) 296 -0803
Foster Care Program: (785) 296 -1270 Fax: (785) 296 -7025
Website: www.kdheks.gov/kidsnet

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 #

I hereby authorize ______________________________ (Name of individual/staff member) and/or

______________________________ (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 ______________

______________________________ (First and Last Name of Child or Youth) while said child or youth is in said facility's

custody between the dates of ______________ and ______________.
MM/DD/YYYY MM/DD/YYYY

Signature of Parent or Guardian	Date Signed

Witness to Parent's or Guardian's signature if required by the local hospital or clinic.	Date Signed

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

State of Kansas
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**
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.

MEDIA RELEASE

I hereby give my consent to all photographs, audiorecordings, academic work, and/or videorecordings taken of my minor child by First Baptist Christian Preschool staff or their designees. I understand that any such photographs, audiorecordings, academic work, and/or videorecordings become the property of First Baptist Christian Preschool and may be used by the school for educational, instructional, or promotional purposes determined by First Baptist Christian preschool in broadcast and electronic media formats now existing or in the future created.

(Please check on the the options below).

______ Yes, I give my consent.

______ No, I do not give my consent.

Date:______________________________

Teacher's Name:______________________________

School's Name:______________________________

Student's Name:______________________________
(Please Print)

Parent's/Guardian's Name:______________________________
(Please Print)

Signature:______________________________
(parent/guardian signature)

Mailing Address______________________________

____

____

Telephone:______________________________

Email Address:______________________________

This consent form is good for 2 years

I WILL NOT HOLD THE FIRST BAPTIST CHRISTIAN PRESCHOOL RESPONSIBLE FOR ANY DISEASE THAT MY CHILD MIGHT CONTRACT, OR FOR ANY ACCIDENT THAT HE/SHE MIGHT SUSTAIN.

SIGNED______________________________

NAME________________________________

RELATIONSHIP TO CHILD____________________

DATE________________________________

FIRST BAPTIST CHRISTIAN PRESCHOOL MEDICAL AUTHORIZATION FORM

I authorize the First Baptist Christian Preschool staff and or Director to take whatever emergency measures are deemed necessary for the protection of (print child's name) ________________while he/she is in their care. I understand that this authorization includes calling my child's physician, implementing his instruction, and possibly transporting my child to a hospital or clinic without first obtaining my consent.

SIGNED______________________________

NAME________________________________

RELATIONSHIP TO CHILD____________________

DATE________________________________

SUBSCRIBED AND SWORN TO BEFORE ME THIS ____ DAY OF ______________, 20___.

____

Notary Public

CCL. 029a
Rev. 8/2013

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): ☐ None	Do you see this child for regular health supervision: ☐ Yes ☐ No
Allergies to food or medicine (describe, if any): ☐ None	
List current medications (if any): ☐ None	

Length/Height: ______IN/CM %ILE______		**Weight: _____LB/KB %ILE______**
Physical Examination	✓ **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) ☐ 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

SCHOOL SUPPLIES

1 - Box of Crayons

2 - #2 Pencils

1 - Set of Watercolors (Prang are best)

1 - Scissors

1 - Box to hold supplies

(Please make sure your child can open & close supply box)

1 - Backpack

1 - Ream of Copy Paper

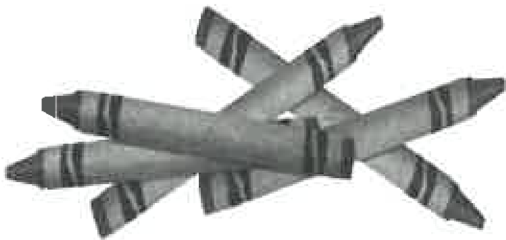
1 - Can or bottle of 100% Juice Concentrate (Not Frozen)

1 - Package of your child's favorite cookie or cracker

PLEASE PUT YOUR CHILD'S NAME ON ALL SUPPLIES

Scissors and glue will be collected and stored for our 3 year olds.

All paint sets will be stored until painting days.



Please plan to keep additional underwear and a change of clothing in your child's backpack and switch it out to fit the weather. Three, four, and five year olds can "still" have accidents and we have found that your children are more comfortable wearing their own clothing.

Thank you!