Confidential Medical Record for School
(To be released only on signature of parent/guardian)

CHILD HEALTH ASSESSMENT

Name:_____ Birthdate:_____
Address:_____ Birthplace:_____
Parent/Guardian:_____ Birth Certificate Number:_____
Address:_____ Phone: Work_____ Home_____
Physician:_____ Date of last examination:_____
Dentist:_____ Date of last examination:_____

HEALTH HISTORY: To be filled out by Parent or Guardian

	Yes	No
1. Are there any chronic illness problems in your family such as heart disease, diabetes, cancer, convulsions or others?	___	___
2. Does any member of family have a visual defect, hearing loss, or spine deformity?	___	___
3. Were there any pre-natal or delivery problems with the child?	___	___
4. Did this child walk, talk, and speak at the usual time?	___	___
5. Does this child:		
(a) See a physician regularly for any illness problem?	___	___
(b) Take any medication regularly?	___	___
(c) Have a history of any hospitalization?	___	___
(d) Have a history of any childhood diseases?	___	___
(e) Have a history of menstrual problems? (If applicable)	___	___
(f) Have a problem with vision, speech, or hearing?	___	___
(g) Have a problem with being shy or overactive?	___	___
(h) Have any emotional problems?	___	___
(i) Need any special help in school?	___	___
(j) Have any chronic illness or handicapping problems such as:		

	Yes	No		Yes	No		Yes	No
Headaches	___	___	Convulsions	___	___	Earaches	___	___
Colds/sore throat	___	___	Rheumatic fever	___	___	Dental	___	___
Heart/lung disease	___	___	Allergies/Asthma	___	___	Urinary/bowel	___	___
Back/spine problems	___	___	Diabetes	___	___	Other	___	___

REMARKS: (Please explain any problem checked)

Immunization: (NOTE: Kansas Certificate of Immunization Form must be presented for entrance into school and if Attached, do not repeat information on this form.)

Circle number of immunizations Received		Date of last Immunization
DPT and/or Td	0 1 2 3 4 5	_____
Oral Polio	0 1 2 3 4 5	_____
Measles	0 1	_____
Rubella	0 1	_____
Mumps	0 1	_____

PHYSICAL EXAMINATION: To be completed by physician or nurse approved to do health assessments

Height:_____ Weight:_____

Head_____ Lungs_____ CNS_____
EENT_____ Breast_____ Skin_____
Dental_____ Abdomen_____ Lymphatics_____
Cardiovascular_____ G.U._____ Musculoskeletal_____

Screening Results:
Development (type of test)_____ Pulse_____
Hearing* Blood Pressure_____
Right_____ Left_____ Hbg or HCT_____
Vision* Urinalysis_____
Right_____ Left_____ Sickle Cell_____
Speech_____ Other_____

*Indicate if you wish these tests to be performed at school.

Significant Assessment Findings:

KANSAS CERTIFICATE OF IMMUNIZATIONS (KCI)

This record is part of the student's permanent record and shall be transferred from one school to another as defined in Section 72-5209 (d) of the Kansas School Immunization Law (amended 1994.)

Student Name: _____ Address: _____

Parent or Guardian Name: _____

Phone: _____

Birthdate (MM/DD/YYYY): _____ SEX: [ ] MALE [ ] FEMALE Race: _____ Ethnicity: _____ County: _____

VACCINE	RECORD THE MONTH, DAY, AND YEAR THAT EACH DOSE OF VACCINE WAS RECEIVED ⊘ = Dose determined invalid by provider ! = Invalid Dose. KSWebIZ minimum age/interval not met						
	1st	2nd	3rd	4th	5th	6th	7th
DTaP/DT/Td/Tdap (Diphtheria, Tetanus, Pertussis) Required for school entry. Single Tdap required for grades 7-12. State Type							
Polio Required for school entry.						If additional doses are added, please initial the dose and sign below:	
HEP B (Hepatitis B) Required for school entry.							
Varicella (Chickenpox) Required for school entry.			Hx of Disease: NO Physician Signature: Date of Illness: _____				
MMR (Measles, Mumps, and Rubella combined) Required for school entry.							
Influenza (Flu) Recommended annually for ages 6mo and older. Not required for school entry.							
HIB (Haemophilus Influenzae Type B) Required < 5 years of age for preschool or child care operated by a school.							
PCV (Pneumococcal Conjugate) Required < 5 years of age for preschool or child care operated by a school.							
HEP A (Hepatitis A) Required < 5 years of age for preschool or child care operated by a school.							
MCV4 (Meningococcal) Initial dose recommended at 11-12 years of age and booster dose recommended after 16 years of age. Not required for school entry.							
HPV (Human Papillomavirus) Recommended for males and females at 11-12 years of age. Not required for school entry.							
Rotavirus Recommended < 8 mo. Not required for school entry.							

DOCUMENTATION

KCI MAY ONLY BE SIGNED BY A PHYSICIAN (MD/DO), HEALTH DEPT, OR SCHOOL.

☐ I certify I reviewed this student's vaccination record and transcribed it accurately

Agency Name:

Authorized Representative:

Address:

The record presented was: Date _____

☐ Kansas Immunization Record

☐ Other Immunization Record (Specify) _____

LEGAL ALTERNATIVES TO VACCINATION REQUIREMENTS "KSA 72-5209"

1. "Annual written statement signed by a licensed physician (Medical Doctor/M.D. or Doctor of Osteopathy/D.O.) stating the physical condition of the child to be such that the tests or inoculations would seriously endanger the life or health of the child." Medical exemption shall be validated annually by physician completion of KCI Form B and attachment to the KCI.

2. "Written statement signed by one parent or guardian that the child is an adherent of a religious denomination whose religious teachings are opposed to such tests or inoculations."

KANSAS IMMUNIZATION PROGRAM
1000 SW Jackson, Suite 210, Topeka, KS 66612-1274
PHONE 877-296-0464 FAX 785-559-4227

I give my consent for information contained on this form to be released to the Kansas Immunization Program for the purpose of assessment and reporting.

_____ _____

Parent/Legal Guardian's Signature Date

KANSAS IMMUNIZATION REQUIREMENTS: Based on age of child as of September 1 of current school year.

As per Kansas Statute 72-5209, all children upon entry to school must be appropriately vaccinated. In each column below, vaccines are required for all ages listed in that column.

Pre-Kindergarten Ages 0-4 ACIP Recommended Schedule

Birth	**HEP B**
2 Months	**DTaP/DT** **POLIO** **HEP B** **PCV** **ROTAVIRUS**
4 Months	**DTaP/DT** **POLIO** **HIB** **PCV** **ROTAVIRUS**
6 Months	**DTaP/DT** **POLIO** **HEP B** **HIB** **PCV** **ROTAVIRUS**
12-15 Months	**MMR** **VAR** **HIB** **PCV**
12-23 Months	**HEP A**
15-18 Months	**DTaP/DT**
6 Months after 1st dose	**HEP A**

ACIP Recommended Schedule
http://www.cdc.gov/vaccines/schedules/

Kindergarten through 12th Grade

DTaP: 5 Doses

a) 4 week minimum interval between first 3 doses; 6 month interval between dose 3 and dose 4
b) 4 doses acceptable if dose 4 given on or after the 4th birthday
c) If dose 4 administered before 4th birthday, 5th dose must be given at 4-6 years of age

Tdap/Td: 7 years and older

3 doses if no history of any DTaP doses (a-b)

a) 4 week minimum interval between dose 1 (Tdap) and dose 2 (Td); first dose must be Tdap
b) 6 months between dose 2 (Td) and 3 (Td)
c) Single dose of Tdap for an incomplete primary DTaP series or;
d) Single dose of Tdap required for Grades 7-12

Polio: Grades K - 7, new students and students completing the polio series <u>All IPV or OPV Schedule</u>

a) 4 week minimum interval between first 3 doses; 6 months interval between dose 3 and dose 4; one dose after 4th birthday
b) 3 doses acceptable, if 4 weeks between dose 1 and 2; 6 months between dose 2 and 3; one dose after 4th birthday

<u>Combination IPV/OPV - 4 doses required</u>

a) 4 week minimum interval between first 3 doses; 6 months interval between dose 3 and dose 4; one dose after 4th birthday
b) 3 doses not acceptable with combination schedule

Polio: Grades 8 - 12th

<u>All IPV or OPV Schedule</u>

a) 4 doses-4 weeks minimum interval betwen doses regardless of age given
b) 3 doses acceptable -4 weeks minimum interval between dose 1 and dose 2; dose 3 after 4th birthday

<u>Combination IPV/OPV - 4 Doses required</u>

a) 4 weeks minimum interval regardless of age given

New students and students completing series must have 6 months between last two doses with one dose after 4th birthday

MMR: 2 doses Grades K - 12th

a) First dose on or after the 1st birthday
b) 28 days minimum interval between doses

Varicella: 2 doses Grades K - 12th

a) First dose on or after the 1st Birthday
b) Second dose must be given at least 28 days after first dose
c) No doses required if prior varicella disease verified by a physician

Varicella-ACIP minimum interval for less than 13 yrs is 3 months; 13 yrs and older is 4 weeks however, a 28 day interval regardless of age is valid.

Hepatitis B: 3 doses Grades K - 12th

a) 4 week minimum interval between dose 1 and dose 2
b) 8 week minimum interval between dose 2 and dose 3
c) 16 week minimum interval between dose 1 and dose 3
d) Dose 3 must be given after 24 weeks of age

Additional Notes:

- Vaccine doses given up to 4 days before the minimum interval or age may be considered valid.
- With the exception of Hepatitis B vaccine, immunizations given before 6 weeks of age are not considered valid.
- Half doses or reduced doses of vaccine are not considered valid.

PARENTS AND/OR GUARDIANS ARE NOT AUTHORIZED TO COMPLETE KCI FORMS.

KCI FORM B - MEDICAL EXEMPTION is located at http://www.kdheks.gov/immunize/imm_manual_pdf/KCI_formB.pdf
BLANK VERSION OF KCI FORM is available at http://www.kdheks.gov/immunize/download/KCI_Form.pdf

A ROSTER WITH THE NAMES OF ALL EXEMPT STUDENTS SHOULD BE MAINTAINED. PARENTS OR GUARDIANS OF EXEMPT CHILDREN SHOULD BE INFORMED THAT THEIR CHILDREN SHALL BE EXCLUDED FROM SCHOOL IN THE EVENT OF AN OUTBREAK OR SUSPECTED CASE OF A VACCINE-PREVENTABLE DISEASE.