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

Kansas Department of Health and Environment

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 #
Beth Shalom Early Childhood Education Center	***0057829***

I authorize ___***Beth Shalom***_______________________________(*caregiver/staff*) 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______________________________ (*child's first and last name)* while child or youth is in the facility's custody between ***beginning of care*** (MM/DD/YYYY) and ***care terminated*** (MM/DD/YYYY).

List any known allergies or other information about the medical conditions of this child or youth pertinent in case of 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.

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Permission Form for Children to go Off-Premises

Name of the Facility (exactly as stated on the license)			License #
Beth Shalom Early Childhood Education Center			***0057829***
Street Address of the Facility	City	Zip Code	County
14200 Lamar Ave	***Overland Park***	***66223***	***Johnson***

_____may go to the following locations off the premises with adult supervision:
First and Last Name of Child or Youth

Place	Street Address	City	By Vehicle	Walk/Bike
Goldsmith Hall	***14200 Lamar Ave***	***Overland Park***		***Walk***
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Downstairs Library	***14200 Lamar Ave***	***Overland Park***		***Walk***
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Sanctuary	***14200 Lamar Ave***	***Overland Park***		***Walk***
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Playroom	***14200 Lamar Ave***	***Overland Park***		***Walk***
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Room 209 (Torah Study)	***14200 Lamar Ave***	***Overland Park***		***Walk***
Signature of Parent or Guardian			Date Signed	

Place	Street Address	City	By Vehicle	Walk/Bike
Room 102 (Music)	***14200 Lamar Ave***	***Overland Park***		***Walk***
Signature of Parent or Guardian			Date Signed	

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Medical Record

Medical History

In accordance with K.A.R. 28-4-117 and K.A.R. 28-4-430, a completed medical record shall be on file for all children in care. For a Family Child Care Home, children under 10 years of age and all children living in the home under 16 years of age, a medical record shall be completed. The Medical Record shall include a Medical History including current Immunizations and a Child Health Assessment. The Medical Record is transferable when the child moves to another licensed child care facility.

Child's First Day in Child Care _____

Name of Child Care Facility **Beth Shalom RFEC**

Child's Name _____ (First Last)

Date of Birth _____ (MM/DD/YYYY) Gender _____ (M/F)

Parent/Guardian Information

Name _____

Home Address _____ (Street City Zip Code)

Home/Cell Phone Number _____

Work Phone Number _____

E-mail Address _____

Best way to contact _____

Parent/Guardian Information

Name _____

Home Address _____ (Street City Zip Code)

Home/Cell Phone Number _____

Work Phone Number _____

E-mail Address _____

Best way to contact _____

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

Name _____

Address _____

Phone Number _____

Name _____

Address _____

Phone Number _____

Child's Physician _____ Phone Number _____

Hospital Preference (for emergencies): _____

Known allergies or medical conditions: _____

Major changes at home that might affect your child in care: _____

Additional information or special instructions that will help the person caring for your child: _____

Parent/Guardian Signature: _____ **Date:** _____

Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____

Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____

Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____

Date of annual review: _____ Parent/Guardian Initials: _____ Provider Initials: _____

Medical Record:

Medical History Cont. - Immunizations

Required for all children in child care facilities, 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/YYYY

Section I. For a recommended schedule of immunizations, refer to the current schedule published by the Advisory Committee on Immunization Practices (ACIP).

Vaccine	Record the Month. Day and Year that each Dose of Vaccine was Received					
	1st	2nd	3rd	4th	5th	6th
Diphtheria, Tetanus, Pertussis (DTaP)						
Poliomyelitis (IPV/OPV)						
Measles, Mumps, Rubella (MMR)						
Hepatitis B (HepB)						
Varicella (VAR)			Hx of Disease: Physician Signature		Date of Illness:	
Hemophilus Influenzae Type B (Hib)						
Pneumococcal Conjugate (PCV)						
Hepatitis A (HepA)						
Rotavirus *Recommended <8 mo.; not required						
Influenza (Flu) *Recommended annually >6 mo.; not required						

Section II.

Complete this section only if your child is exempted from the law requiring immunizations [K.S.A. 65-508(g)].

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:

☐ DTaP/DT ☐ Tdap/TD ☐ Pertussis Only ☐ Polio ☐ MMR ☐ Hep A ☐ Hep B
☐ Hib ☐ PCV ☐ Varicella ☐ Other (describe): _____

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: _____

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Medical Record:
Child Health Assessment

The Child Health Assessment form is to be completed and signed by a nurse approved to perform health assessments, a licensed physician, or physician's assistant (PA). The health assessment shall be conducted not more than 12 months before and no later than 60 calendar days after enrollment at the child care facility.

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 Family Child 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.

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/KG %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 pages if necessary)
☐ None

Signature of Licensed Physician or Nurse approved for Child Health Assessment	**Date**
Print the Name of the Individual Signing Above	Phone Number
Address City	Zip Code