FCL 053
Rev. 11/18

KANSAS DEPARTMENT FOR CHILDREN AND FAMILIES
Foster Care Licensing and Background Checks Division
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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: _____ Zip:_____

Parent/Guardian: _____ Work Phone: _____ Home: _____

Child lives with: _____ Work Phone: _____ Home: _____

Number in household: _____ Type of family housing: _____

Physician: _____ 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	Comment
1	Are there any chronic illness problems in your family such as heart disease, diabetes,		
2	Does any family member have a vision defect, hearing loss or spinal deformity? Comment.		

CHILD/ADOLESCENT HISTORY

Response Codes: ***Y = Yes*** ***N = No*** ***NA = Not applicable***

1.	Birth weight _____ Were there any pre-natal or delivery problems 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 room 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 problems?		
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?		
l	Have any chronic illness or disabling problems with:		

Headache	__	Convulsions	_____	Diabetes	_____	Earaches	_____	Back/spine/	
Colds/sore throat	__	Rheumatic fever	_____	Genitalia	_____	Oral/dental	_____	extremity problems	____
Heart/lung disease	__	Allergies/Asthma	_____	Digestive	_____	Urinary/bowel	_____	Other	____

List present concerns of child/parent/guardian/foster parent:

Immunization: Record **date** of each dose received (mm/dd/yy)						***Required**	****Recommended**			
	1st	**2nd**	**3rd**	**4th**	**5th**		**1st**	**2nd**	**3rd**	**4th**
DPT (Diphtheria, pertussis, tetanus)*						**MMR** (Measles, Mumps, Rubella) *				
Td/DT *						**HBV** (Hepatitis B) **				
OPV or IPV (Polio) *						**TB** (Skin Test) *	Date	Result		
Immunization: Record **date** of each dose received (mm/dd/yy)						***Required**	****Recommended**			

PHYSICAL EXAMINATION: To be completed by health care provider approved to perform health assessments.

Height _____ Weight _____ Hgb or Hct _____
Pulse _____ Blood Pressure _____ Lead _____
Urinalysis _____ Sickle Cell _____ Other _____
Tuberculosis _____ Head Circumference _____

Code Each Item as Follows: 0 = No significant findings 1 = Significant findings	Code	Description of Findings
General Appearance Integument Head - Neck EENT Oral - Dental Thorax Breasts Cardiovascular Abdomen Musculoskeletal Genitourinary Neurological		

SCREENING

1. Nutritional Evaluation (all ages - each screen) (✓ if applicable) Nutrition/WIC Questionnaires available from (785) 296-0092.
☐ Enrolled in WIC ☐ Receiving Vitamin Supplement with iron ☐ Without iron ☐ Fluoride Supplement
Food intake review. Results:
milk/milk products (breast-fed/type of formula) _____
fruit/vegetables _____
meat, beans, eggs _____
breads, cereals _____

Type of screen

2. Developmen _____ Result _____
3. Speech _____ Result _____
4. Hearing _____ Result _____ Date of last screen _____
5. Vision _____ Result _____ Date of last screen _____

Significant Assessment Findings:

Recommendations: (include referrals)

Follow Up:

Anticipatory Guidance: (circle those discussed)

1. Safety/poisons
2. Nutrition
3. Parenting
4. Family Planning
5. Discipline
6. Immunizations
7. Hygiene
8. Lifestyle
9. Development
10. Behavior
11. Sexuality
12. Dental
13. Other

Comments:

Additional Information may be attached

_____ _____

Signature of Licensed Physician or Nurse approved to perform health assessments Date