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KANSAS DEPARTMENT FOR CHILDREN AND FAMILIES
Foster Care Licensing and Background Checks Division
PO BOX 1424 ● Topeka, KS 66601-1424
500 SW Van Buren St ● 2nd Floor ● Topeka, KS 66603
Fax: (785) 296-8609

Kansas Department for Children and Families
Strong Families Make a Strong Kansas

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***

	Question	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***

	Question	Code	Comment
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/ extremity problems _____	
Colds/sore throat __	Rheumatic fever _____	Genitalia _____	Oral/dental _____	Other _____	
Heart/lung disease __	Allergies/Asthma _____	Digestive _____	Urinary/bowel _____		

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