CCL. 358
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Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: (785) 296-1270 Fax (785) 559-4244
Website: www.kdheks.gov/kidsnet

HEALTH HISTORY FOR CHILDREN AND YOUTH ATTENDING SCHOOL AGE PROGRAMS

As required by K.A.R. 28-4-590(d) (1), each operator shall obtain a health history for each child or youth, on a form supplied by the department or approved by the secretary. Each health history is to be maintained in the child's or youth's file on the premises. As required by K.A.R. 28-4-590(d)(2), each operator shall require that each child or youth attending the program has current immunizations as specified in K.A.R. 28-1-20 or has an exemption for religious or medical reasons.

Complete one form for each child or youth attending the School Age Program.

First and Last Name of the Child or Youth	Gender (M or F)	Date of Birth (MM/DD/YYYY)	First day at this program: (MM/DD/YYYY)

First and Last Name of the Child's or Youth's Mother or Guardian

Mother/Guardian's Home Street Address	City	Zip Code	Home Phone # ( )

Mother/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ( )

First and Last Name of the Child's or Youth's Father or Guardian

Father/Guardian's Home Street Address	City	Zip Code	Home Phone # ( )

Father/Guardian's Work Place Name & Street Address	City	Zip Code	Work Phone # ( )

Names and ages of other children in the Child or Youth's Family (Attach additional page if needed.)

Person(s) authorized to pick up the Child or Youth in case of emergency. Include first and last name and Street Address. Attach additional page if needed.	City	Zip Code	Phone Number (during program hours):
1.			
2.			
3.			

First and Last Name of Physician & Street Address	City	Zip Code	Phone Number ( )

Name of Hospital Preference in case of emergency.

Yes	No	N/A	Complete the following information about medications for this child or youth.
◯	◯		Will this child or youth need to take any nonprescription or prescription medication during their time at the program?
◯	◯	◯	If yes above, is there signed permission on file?

Circle any of the following conditions or difficulties that affect this child or youth.			
Allergies ☐	**Frequent sore throats/ colds** ☐	**Ear Infections or Aches** ☐	**Heart or Lung Conditions** ☐
Skin Problems ☐	**Asthma** ☐	**Headaches** ☐	**Diabetes** ☐
Vision ☐	**Speech/Communication** ☐	**Hearing** ☐	**Emotion/Behavior** ☐
Other: Please describe.			

If you circled any of the above conditions, please provide additional information that will help the staff members meet the child's or youth's needs while attending the program. (Attach additional page, if needed.)

Provide additional information about your child or youth that might affect him/her while at the School Age Program including any special needs, restrictions to activities, major changes at home or special instructions. (Attach additional page, if needed.

Complete the following information about this child's or youth's immunization status.

Yes	No	
◯	◯	**Did this child or youth attend a public or accredited non-public school in Kansas, Missouri or Oklahoma the previous year?**
◯	◯	**If yes, are this child's or youth's immunizations current?**
☒	☒	**If yes to both of these questions, you do NOT need to complete the immunization history below. If no to either of the above questions, you must complete the immunization history below for this child or youth or attach a copy of the child's or youth's immunization history.**

Please give dates in the space below for ALL immunization series completed by this child or youth. Record MM/DD/YYYY.

		1	2	3	4	5
	DPT, DT*, TD (*DT only if child is allergic to DTP)	/ /	/ /	/ /	/ /	/ /
	POLIO	/ /	/ /	/ /	/ /	
	MMR	/ /	/ /			
Single Dose Only	RUBEOLA (MEASLES)	/ /	/ /			
	MUMPS	/ /	/ /			
	RUBELLA (GERMAN MEASLES)	/ /	/ /			
	HIB (Hemophilus Influ. B) *RECOMMENDED	/ /	/ /	/ /	/ /	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	/ /	/ /	/ /		
	VAR (Varicella-Chicken Pox) *RECOMMENDED	/ /				

Print the First and Last Name of the Person Completing this Health History form	Relationship to the Child/Youth	Date Completed

If the Health History form was completed by a person other than a Parent/Guardian, who provided you with this information?	What is that person's relationship to the child/youth?

I attest, under penalty of perjury, that to the best of my knowledge, the information provided on this form is true and correct.

Signature of person completing this form	Date Signed

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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 authorize _____City of Olathe Park & Recreation Staff____ (*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 ___01/01/2021____________________ and _____Until Terminated_____________________.
MM/DD/YYYY MM/DD/YYYY

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: ___________________________________
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**

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: ___________________________

- -

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.

FIRST AID PERMISSION SLIP

I give my permission for the City of Olathe Parks & Recreation Staff to use the appropriate first aid supplies (sunscreen, bug spray, first aid cream, antiseptic wipes, after bite, etc.) on my child, _____, as necessary during camp.

Print Name_____

Parent Signature_____

Date: _____

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PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS

Name of the Facility (exactly as stated on the license)			**License #**
All Olathe Parks & Recreation Licensed School-Age Programs			
Street Address of the Facility	**City**	**Zip Code**	**County**
	Olathe	66062 or 66061	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**
All Areas of Black Bob Park	14500 W. 151st St.	Olathe	X	X
Signature of Parent or Guardian			**Date Signed**	

Place	**Street Address**	**City**	**By Vehicle**	**Walk/Bike**
All Areas of Lake Olathe Park	191 N Ward Cliff Dr.	Olathe	x	x
Signature of Parent or Guardian			**Date Signed**	

Place	**Street Address**	**City**	**By Vehicle**	**Walk/Bike**
All Areas of Oregon Trail Park	1100 S Robinson	Olathe	X	X
Signature of Parent or Guardian			**Date Signed**	

Place	**Street Address**	**City**	**By Vehicle**	**Walk/Bike**
All Areas of Two Trails Park	1000 N Ridgeview Rd.	Olathe	X	X
Signature of Parent or Guardian			**Date Signed**	

Place	**Street Address**	**City**	**By Vehicle**	**Walk/Bike**
Olathe Community Center	1205 E Kansas City Rd.	Olathe	X	X
Signature of Parent or Guardian			**Date Signed**	

Place	**Street Address**	**City**	**By Vehicle**	**Walk/Bike**
Signature of Parent or Guardian			**Date Signed**	

Place	**Street Address**	**City**	**By Vehicle**	**Walk/Bike**
Signature of Parent or Guardian			**Date Signed**	

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Authorization for Dispensing Medications to Children and Youth
Short-Term Medications (Prescription and Non-Prescription)

Prescription medication must be in their original containers labeled with the child's/youth's first and last name; the name of the licensed physician, physician assistant (PA), or advanced practice registered nurse (APRN) who ordered the medication; the date the prescription was filled; the expiration date of the medication; and specific, legible instructions for administration and storage of the medication. Administer the medication only to the child/youth designated on the prescription label in accordance with the instructions on the label. **Non-prescription medications** can be given with written permission and direction from the parent or legal guardian. Administer nonprescription medication from the original container labeled with the first and last name of the child/youth and according to the instructions on the label.

Medication #1

_____
First and Last Name of Child/Youth Date of Birth

_____
Name of Medication

_____
Reason for Medication

_____
Dose Time to be Given Stop Date

_____
Name of Licensed Physician/PA/APRN prescribing the medication

(_____)_____
Phone Number of Physician, PA, or APRN

I allow the above medication to be given to my child/youth by the designated person.

_____
Parent's Signature Date

Medication #2

_____
First and Last Name of Child/Youth Date of Birth

_____
Name of Medication

_____
Reason for Medication

_____
Dose Time to be Given Stop Date

_____
Name of Licensed Physician/PA/APRN prescribing the medication

(_____)_____
Phone Number of Physician, PA or APRN

I allow the above medication to be given to my child/youth by the designated person.

_____
Parent's Signature Date

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION(S) IDENTIFIED ABOVE.
Designated Person to note any comments or remarks about the child's/youth's appearance on the back of this form.
***Each designated person administering medication is to sign on the back side of this form and identify initials used.**

Date mm/dd/yy	Time	Name of Medication	*Initials	Date mm/dd/yy	Time	Name of Medication	*Initials

*Signature of Designated Person Administering Medication _____ Initialing as_____

*Signature of Designated Person Administering Medication _____ Initialing as_____

*Signature of Designated Person Administering Medication _____ Initialing as_____

*Signature of Designated Person Administering Medication _____ Initialing as_____

Note Form

Date	Additional comments about the incident or other related incidents, including comments or remarks about the child's/youth's appearance and/or condition.