CCL. 009 Rev. 8/2013

Kansas Department of Health and Environment

Bureau of Family Health 1000 SW Jackson, Suite 200 Topeka, KS 66612-1274

Child Care Program: (785) 296 -1270 Fax: (785) 296 -0803 Foster Care Program: (785) 296 -1270 Fax: (785) 296 -7025

Website: www.kdheks.gov/kidsnet



CERTIFICATE OF HEALTH ASSESSMENT FOR PERSONS 16 YEARS OF AGE OR OLDER

K.A.R. 28-4-126(b)(1) requires each person over 16 years of age regularly caring for children to have a health assessment completed by a licensed physician or by a nurse trained to perform health assessments. Temporary substitutes in a licensed day care home or licensed group day care home are not required to obtain a health assessment. All persons over 16 years of age living in a Family Foster Home [K.A.R. 28-4-316(b)(1)] must have a health assessment. A Physician Assistant (PA) may complete the health assessment and must include the signature of the licensed physician authorizing the PA. The Health Assessment must be recorded on this KDHE form. Substitute forms are not accepted.

то	BE COMPLETED BY PROVID	DER/STAFF	(Please print)					
Nam	e of the facility (exactly as sta	License #						
Stre	et Address		City		Zip Code	County		
Che	ck type of child care facility:							
	Licensed Day Care Home	☐ Pre	eschool		Attendant Care Facility	y 🚨 Maternity Center		
	Group Day Care Home	☐ Sc	hool Age Program		Detention Center	☐ Residential Center		
	Child Care Center	□ не	ead Start Center		Family Foster Home	☐ Secure Residential Treatment Facility		
					Group Boarding Home	☐ Secure Care Center		
Nam	e of Provider/Staff					Date of Birth		
	(First)		(Middle)		(Last)	(MM/DD/YYYY)		
Plea 1. 2. 3. 4.	se check each question. If ar Do you see a physician re Are you taking any medic Have you have any surger Do you have any handica interfere with the care of Do you have any chronic	egularly for cation regulary in the passepping concohildren?	any health condition? arly? st 3 years? litions which might		Yes No			
Hear High Lunç	daches t Disease Blood Pressure g Disease her, Describe:	<u>No</u>	Cancer Diabetes Convulsions Mental Illnes		<u>Yes</u> <u>No</u>	Alcoholism Arthritis Cher Cher Alcoholism Arthritis Cher Cher Arthritis Cher Che		
						ORM HEALTH ASSESSMENTS:		
1.	I do not find evidence of children.	physical or	mental illness that w	ould	conflict with the ability t	to care for the health, safety or welfare of		
Sig	gnature of Licensed Physici	an or Nurs	e trained to perform	hea	Ith assessments.	Date (MM/DD/YYYY)		
2.	I found evidence of physichildren.	sical or mer	ntal illness that would	conf	lict with the ability to car	re for the health, safety or welfare of		
Si	gnature of Licensed Physic	ian or Nurs	se trained to perform	hea	alth assessments.	Date (MM/DD/YYYY)		
Nega symp	ord results of TB test or atta tive tuberculin test or negat toms.)				(date) (Re	epeat test not needed unless there is exposure or		
Test	read by Licensed Phys	ician/Nurse	Signature or Health De	part	ment	Date (MM/DD/YYYY)		

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Child Care Licensing Program
1000 SW Jackson Street, Suite 200
Topeka, KS 66612-1274
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Website: www.kdheks.gov/kidsnet



Notification of Injury, Illness or Critical Incident

This form is to be used to report injury or illness of children or youth in child care or school age programs.	d care or school age programs.		
Name of Facility (exactly as it appears on the license):	License #:		Date Completed (MM/DD/YYYY):
Street Address of Facility:	City:	County:	
SECTION I: TYPE OF NOTIFICATION:			
less Injury	Critical Incident such as missing child, fire, etc.	d, fire, etc.	
Provide a summary of the incident:			
First and Last Name of Child or Youth:		Date of Bi	Date of Birth (MM/DD/YYYY):
First and Last Name of adult(s) responsible and/or observing the incident:		Relationshi (Staff mem	Relationship to the Facility: (Staff member, Volunteer, etc.)

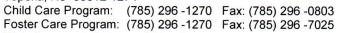
SECTION III: DESCRIPTION OF INJURY, ILLNESS OR CRITICAL INCIDENT:

Signature:	Print First and	attest, under p					Date		Date of Incident (MM/DD/YYYY)	
	Print First and Last Name of Individual Completing This Form:	attest, under penalty of perjury, that to the best of my knowledge, the information provided on				Collillelis/Relidins	Comments/Remarks		Description of Injury, Illness or Critical Incident including what happened, time of day, location of children or youth at the time, etc.	
								NOTES	Remarks about the child's initial appearance and condition if illness or injury	
Date Signed (MM/DD/YYYY):		this form is true and correct.	rm is true and correct.					ANG HERMANNE		Action taken by the facility. What did you do?
D/YYYY):				-			CARLETTE & STREET, BASE OF P.		Was Medical attention required? (Yes or No). If so, describe and note if on site or transported to clinic/hospital.	

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YEARLY MECHANICAL SAFETY CHECK FOR VEHICLES USED TO TRANSPORT CHILDREN IN A CHILD CARE FACILITY

Complete a form for each vehicle used to transport children. A record of the check and corrections shall be kept on file at the facility or in the vehicle.

In accordance with K.A.R. 28-4-130(listed for the vehicle identified on this	(a)(2)(B), a yearly mec s form:	hanical safety che	eck has been completed or	the items						
Tires	Make of car:		Year:	_						
Lights Windshield wipers Horn	Number of individ	ual restraints:		- Y						
Signal lights Steering	Vehicle Insurance	Policy No:		_						
Suspension Glass	In accordance with	In accordance with K.A.R. 28-4-130(a) (3), liability limits are:								
Brakes Tail lights Exhaust system Outside mirror	Personal injury or death in any one accident: Personal injury or death to two or more persons in any one accident: Loss of property:									
The safety check may be completed safety check was completed by	by the applicant or an	y designee who a	on							
	First	Last	(MM/DD/YYY))						
In accordance with K.A.R. 28-4-130(kit contains the following:	a)(4)(B), a first aid kit i	s required in vehi	icles transporting children.	The first aid						
 Band-aids (all sizes) 1 pkg. gauze squares Cleansing agent (green soand to elastic bandage) Adhesive tape Roll of gauze Scissors 	p, pump soap antisepti	c ointment or spra	ay is acceptable)							
Facility Name Exactly as it Appears	on the License	Lice	ense Number							
Street Address	С	ity	County							
I attest that this information is true	e and correct.									
Signature for Facility		Da	ite (MM/DD/YYYY)							