CCL. 009
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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.

TO BE COMPLETED BY PROVIDER/STAFF (Please print)

____ _______________________
Name of the facility (exactly as stated on the license) License #

____
Street Address City Zip Code County

Check type of child care facility:

- ❑ Licensed Day Care Home
- ❑ Group Day Care Home
- ❑ Child Care Center
- ❑ Preschool
- ❑ School Age Program
- ❑ Head Start Center
- ❑ Attendant Care Facility
- ❑ Detention Center
- ❑ Family Foster Home
- ❑ Group Boarding Home
- ❑ Maternity Center
- ❑ Residential Center
- ❑ Secure Residential Treatment Facility
- ❑ Secure Care Center

Name of Provider/Staff ____________________________________ Date of Birth ____________________
(First) (Middle) (Last) (MM/DD/YYYY)

Please check each question. If answer is yes, please explain.

		Yes	No
1.	Do you see a physician regularly for any health condition?	___	___
2.	Are you taking any medication regularly?	___	___
3.	Have you had any surgery in the past 3 years?	___	___
4.	Do you have any handicapping conditions which might interfere with the care of children?	___	___
5.	Do you have any chronic illness conditions such as:		

	Yes	No		Yes	No		Yes	No
Headaches	___	___	Cancer	___	___	Alcoholism	___	___
Heart Disease	___	___	Diabetes	___	___	Arthritis	___	___
High Blood Pressure	___	___	Convulsions	___	___	Liver Disease	___	___
Lung Disease	___	___	Mental Illness	___	___	Other	___	___

If Other, Describe: ____

TO BE COMPLETED BY LICENSED PHYSICIAN, OR NURSE TRAINED TO PERFORM HEALTH ASSESSMENTS:

I have reviewed the above information and have conducted an examination and any tests indicated. Sign one of the statements below: (1 OR 2)

1. **I do not find** evidence of physical or mental illness that would conflict with the ability to care for the health, safety or welfare of children.

____ _______________________
Signature of Licensed Physician or Nurse trained to perform health assessments. **Date (MM/DD/YYYY)**

2. **I found evidence** of physical or mental illness that would conflict with the ability to care for the health, safety or welfare of children.

____ _______________________
Signature of Licensed Physician or Nurse trained to perform health assessments. **Date (MM/DD/YYYY)**

Record results of TB test or attach results to this form.
Negative tuberculin test ____ or negative chest x-ray ____ on ______________________ (date) (Repeat test not needed unless there is exposure or symptoms.)

Test read by ____ _______________________
Licensed Physician/Nurse Signature or Health Department **Date (MM/DD/YYYY)**

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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.

Name of Facility (exactly as it appears on the license):	**License #:**	**Date Completed (MM/DD/YYYY):**

Street Address of Facility:	**City:**	**County:**

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SECTION I: TYPE OF NOTIFICATION:

Indicate type of report: _____ **Illness** _____ **Injury** _____ **Critical Incident such as missing child, fire, etc.**

Provide a summary of the incident:

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SECTION II: WHO WAS INVOLVED:

First and Last Name of Child or Youth:	**Date of Birth (MM/DD/YYYY):**

First and Last Name of adult(s) responsible and/or observing the incident:	**Relationship to the Facility:** **(Staff member, Volunteer, etc.)**

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

Date of Incident (MM/DD/YYYY)	Description of Injury, Illness or Critical Incident including what happened, time of day, location of children or youth at the time, etc.	Remarks about the child's initial appearance and condition if illness or injury	Action taken by the facility. What did you do?	Was Medical attention required? (Yes or No). If so, describe and note if on site or transported to clinic/hospital.

NOTES

Date	Comments/Remarks

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

Print First and Last Name of Individual Completing This Form:	
Signature:	Date Signed (MM/DD/YYYY):

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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(a)(2)(B), a yearly mechanical safety check has been completed on the items listed for the vehicle identified on this form:

_____ Tires
_____ Lights
_____ Windshield wipers
_____ Horn
_____ Signal lights
_____ Steering
_____ Suspension
_____ Glass
_____ Brakes
_____ Tail lights
_____ Exhaust system
_____ Outside mirror

Make of car: ____________________ Year: ____________

Number of individual restraints: ____________________________

Vehicle Insurance Policy No: ____________________________

In accordance with K.A.R. 28-4-130(a) (3), liability limits are:

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 by the applicant or any designee who agrees to attest to vehicle safety. The safety check was completed by ____________________________________ on ________________________.
First Last (MM/DD/YYYY)

In accordance with K.A.R. 28-4-130(a)(4)(B), a first aid kit is required in vehicles transporting children. The first aid kit contains the following:

- Band-aids (all sizes)
- 1 pkg. gauze squares
- Cleansing agent (green soap, pump soap antiseptic ointment or spray is acceptable)
- 1 elastic bandage
- Adhesive tape
- Roll of gauze
- Scissors

____ ______________________________
Facility Name Exactly as it Appears on the License License Number

____
Street Address City County

I attest that this information is true and correct.

____ ______________________________
Signature for Facility Date (MM/DD/YYYY)