CCL 009 Rev. 2/2010

## Kansas Department of Health and Environment

Child Care Licensing and Registration Program 1000 SW Jackson, Suite 200 Topeka, KS 66612-1274 Phone: (785) 296-1270 Fax (785) 296-0803

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. Substitutes in a licensed day care home or licensed group day care home or registered family 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 FILLED OUT BY CARE GIVER. (Please print)

Child Care Center  Name of Provider/Staff  (First)  (M)  (Last)  Date of Birth  (MM/DD/YYYY)  Please check each question. If answer is yes, please explain.  Do you see a physician regularly for any health condition?  Are you taking any medication regularly?  Are you taking any medication regularly?  Do you have any handicapping conditions which might interfere with the care of children?  Do you have any chronic illness conditions such as:  Yes No Yes No Alcoholism Training Alcoholism Training	Name of the facility exactly as stated on the license or certificate								License/Certificate #		
Reg. Family Day Care Home Preschool Age Program Detention Center Residential Center Residential Center Group Day Care Home School Age Program Detention Center Residential Center Residential Center Scoure Residential Treatment Facility Child Care Center Head Start Center Group Day Care Home Secure Residential Treatment Facility Child Care Center Group Boarding Home Secure Care Center Name of Provider/Staff (First) (M) (Last) Date of Birth (MM/DD/YYYY)  Please check each question. If answer is yes, please explain. (MM/DD/YYYY)  Please check each question. If answer is yes, please explain. (MM/DD/YYYY)  Please check each question. If answer is yes, please explain. (MM/DD/YYYY)  Please check each question. If answer is yes, please explain. (MM/DD/YYYY)  Please check each question. If answer is yes, please explain. (MM/DD/YYYY)  Please check each question. If answer is yes, please explain. (MM/DD/YYYY)  Please check each question. If answer is yes, please explain. (MM/DD/YYYY)  Please check each question. If answer is yes, please explain. (MM/DD/YYYY)  Please check each question. If answer is yes, please explain. (MM/DD/YYYY)  Please check each question. If answer is yes, please explain. (MM/DD/YYYY)  Please check each question. If answer is yes, please explain. (MM/DD/YYYY)  Please check each question. If answer is yes, please explain. (MM/DD/YYYY)  Please check each question. If answer is yes, please explain. (MM/DD/YYYY)  Please check each question. If answer is yes, please explain. (MM/DD/YYYY)  Please check each question. If answer is yes, please explain. (MM/DD/YYYY)  Please check each question. If answer is yes, please explain. (MM/DD/YYYY)  Please check each question. If answer is yes, please explain. (MM/DD/YYYY)  Please check each question. If answer is yes, please explain. (MM/DD/YYYY)  Please check each question. If answer is yes, please explain. (MM/DD/YYYY)  Please check each question. If answer is yes, please explain. (MM/DD/YYYY)  Please check each question. If answer is yes, please explain. (MM/DD/Y	Stre	et Address		City		Zip Code			County		
" Licensed Day Care Home " School Age Program " Detention Center " Residential Center " Group Day Care Home " Head Start Center " Family Foster Home " Secure Residential Treatment Facility " Child Care Center " Group Boarding Home " Secure Care Center " Secure Care Center " Group Boarding Home " Secure Care Center " Secure Care Center " Group Boarding Home " Secure Care Center " Secure Care Center " Group Boarding Home " Secure Care Center " Secure Care Care Center " Secure Care Care Care Care Care Care Care Ca	Che	ck type of child care facility:									
Group Day Care Home	ш	Reg. Family Day Care Home	ш	Preschool	и	Attenda	ant Care	Facility	" Maternity (	Center	
* Child Care Center	ш	Licensed Day Care Home	ш	School Age Program	и	Family Foster Home		" Secure Residential Treatment Facility			
* Child Care Center	ш	Group Day Care Home	ш	Head Start Center	и						
Please check each question. If answer is yes, please explain.   Yes   No	u				и						
Please check each question. If answer is yes, please explain.   Yes   No	Nam	e of Provider/Staff							Date of Birth		
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:  Headaches Yes No Cancer Alcoholism Yes No Headaches Diabetes Anthritis High Blood Pressure Convulsions Liver Disease Convulsions Liver Disease Convulsions Liver Disease Convulsions Co				(M)	(Las	st)				(MM/D	D/YYYY)
Headaches	Plea 1. 2. 3. 4.	Do you see a physician reg Are you taking any medical Have you had any surgery Do you have any handicap interfere with the care of ch	ularly ion re in the ping o	y for any health condition egularly? e past 3 years? conditions which might n?	n?		<u>Yes</u> 	<u>No</u>			
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	Hear High Lung	daches t Disease Blood Pressure Disease	<u>No</u> ——	Diabetes Convulsion		<u>Yes</u> —— ——	<u>No</u> ————————————————————————————————————		Arthritis Liver Disease	<u>Yes</u> —— ——	<u>No</u>
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		ve reviewed the above informa w: (1 OR 2) I do not find evidence of p	ation	and have conducted a	an exa	aminatio	n and ar	ny tests	indicated. Sign o	one of the	statements
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	Sign	ature of Licensed Physician o	or Nu	irse trained to perform	heal	th asses	sments.		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	2.		al or	mental illness that woul	ld con	flict with	the ability	y to care	for the health, saf	ety or welfa	are of
Negative tuberculin test or negative chest x-ray on (date) (Repeat test not needed unless there is exposure or symptoms.)  Test read by	Signature of Licensed Physician or Nurse trained to perform health assessments.								Date	(MM/DD/	YYYY)
	Nega	tive tuberculin test or negative					(d	ate) (Rep	eat test not needed i	unless there	is exposure or
	Test		n/Nur	se Signature or Health De	partm	ent			Date	(MM/DD/Y	YYY)