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
Website: www.kdheks.gov/kidsnet

CERTIFICATE OF HEALTH ASSESSMENT

K.A.R. 28-4-126(b)(1) requires each person 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 are not required to obtain a health assessment. A Physician's Assistant (PA) may complete the health assessment. The health assessment must be recorded on the KDHE form.

CHILD CARE FACILITY: ❑ Licensed or Group Day Care Home ❑ Child Care Center/Preschool/Head Start

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

_____
Street Address City Zip Code County

TO BE COMPLETED BY PROVIDER/STAFF (Please print and answer all questions in this section):

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

Check below any chronic illness(es) or list any medications that may interfere with child care duties:

☐ Debilitating Headaches/Migraines ☐ Cancer ☐ Active Substance Abuse ☐ Heart Disease
☐ Hearing or Vision ☐ Diabetes ☐ Arthritis ☐ High Blood Pressure
☐ Convulsions ☐ Liver Disease ☐ Lung Disease ☐ Mental Illness
☐ Use of any durable medical equipment (walker, cane, oxygen, etc.), describe: _____
☐ List any other medical condition that would interfere with child care duties: _____
☐ List any medications that would interfere with child care duties: _____

CHILD CARE DAY DUTIES MAY INCLUDE*:

- Lifting and carrying children
- Close contact with children
- Driver of vehicle
- Evacuation of children in an emergency
- Stooping/bending
- Facility maintenance
- Food preparation
- Ability to supervise and engage in child care activities
- Use of stairs (up and down)
- Recordkeeping

I certify that this information contains no willful misrepresentation or falsification and that it is true and complete to the best of my knowledge and belief. I hereby authorize the Kansas Department of Health and Environment to contact the persons listed on this form. I understand that the Department may contact others, seek verification of any and all information on this form. I understand that any willful misrepresentation is cause for immediate denial of the application or later revocation of the license.

Provider/Staff Signature _____ Date: _____

TO BE COMPLETED BY A PERSON AUTHORIZED TO PERFORM HEALTH ASSESSMENTS:

I have reviewed the above information, conducted an examination and any required tests. The above patient:

❑ **Does not** have evidence of a medical condition or mental illness that would interfere with typical child care duties listed above.*

_____
Authorizing Signature **Date**

I have reviewed the above information, conducted an examination and any required tests. The above patient:

❑ **Does** have evidence of a medical condition or mental illness that would interfere with typical child care duties listed above.*

_____
Authorized Signature **Date**

Name of office/clinic (Please Print): _____

_____
Street Address City Zip Code Telephone Number

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)**