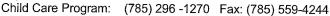
CCL. 009 Rev. 3/2020

Kansas Department of Health and Environment

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



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 # TO BE COMPLETED BY PROVIDER/STAFF (Please print and answer all questions in this section): Name of Provider/Staff (Middle) (First) (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 Stooping/bending Use of stairs (up and down) Close contact with children Facility maintenance Recordkeeping Driver of vehicle Food preparation Evacuation of children in an emergency · Ability to supervise and engage in child care activities 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 TO BE COMPLETED BY A PERSON AUTHORIZED TO PERFORM HEALTH ASSESSMENTS: I have reviewed the above information, conducted an I have reviewed the above information, conducted an examination and any required tests. The above patient: examination and any required tests. The above patient: ☐ Does <u>not</u> have evidence of a medical condition or mental ☐ Does have evidence of a medical condition or mental illness illness that would interfere with typical child care duties listed that would interfere with typical child care duties listed above.* above.* **Authorizing Signature** Date **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

Licensed Physician/Nurse Signature or Health Department

unless there is exposure or symptoms.)

Test read by

Date (MM/DD/YYYY)