CCL. 009
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Kansas Department for Aging and Disability Services
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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	☐ Preschool	☐ Attendant Care Facility	☐ Maternity Center
☐ Group Day Care Home	☐ School Age Program	☐ Detention Center	☐ Residential Center
☐ Child Care Center	☐ Head Start Center	☐ Family Foster Home	☐ Secure Residential Treatment Facility
		☐ Group Boarding Home	☐ 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)**