PARENT'S STATEMENT ON HEALTH OF CHILD

ND DEPARTMENT OF HUMAN SERVICES/CFS

SFN 847 (Rev. 11-2008)

INSTRUCTIONS: This form must be completed annually for any child enrolled in a licensed early childhood facility. This form is completed by a parent or guardian of the child.

Full Legal Name of Child:	Birth Date:	Enrollment Date:	Please check one: ☐ FT ☐ PT ☐ Dropin ☐ B/A School
Full Legal Name(s) of Parent or Guardian:			Relationship:
Address:	City:	State:	ZIP Code:
Home Telephone Number:	Work Telephone Number:	Family Dentist:	
Family Physician:	Clinic:	Telephone Number:	
Hospital:		Telephone Number:	
Last Visit to Doctor:	Child's Height:	Child's Weight:	

Does The Child Have Any food, medication or environmental allergies: ☐ Yes ☐ No

If Yes, List Allergies:	Describe Allergy Reaction:	Usual Treatment:

Please Check If Any Of The Following Conditions Exist:

☐ Asthma ☐ Heart Condition ☐ Hearing Impairment ☐ Behavioral Issues

☐ Diabetes ☐ Seizure Disorder ☐ Frequent Earaches ☐ Other Conditions (please specify): _____

☐ Vision Impairment

Please Explain All Checked Items:

Is The Child Under Current Medical Treatment? ☐ Yes ☐ No If yes, please list:

Are There Any Medications That The Child Takes Daily? ☐ Yes ☐ No If yes, please list:

Describe Any Limitation Your Child May Have For Participation In An Early Childhood Program:

Is there a health care plan for your child? ☐ Yes ☐ No If yes, please attach

INSURANCE:
Liability insurance is not a requirement for a license to provide family or group child care. Please review with your child care provider the liability coverage that is presently in place.

CERTIFICATION:
I certify that the above information is true to the best of my knowledge.

Parent or Guardian's Signature:	Date