# PARENT'S STATEMENT ON HEALTH OF CHILD

ND DEPARTMENT OF HUMAN SERVICES/CFS

SFN 847 (Rev. 11-2008)

Clear Fields

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.

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|---|---|---|---|
| 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 |