# Parent's Statement on Health of Child

**ND Department of Human Services/CFS**  
SFN 847 (Rev. 11-2009)

**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.

<table>
<thead>
<tr>
<th>Full Legal Name of Child:</th>
<th>Birth Date:</th>
<th>Enrollment Date:</th>
<th>Please check one:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Legal Name(s) of Parent or Guardian:</td>
<td></td>
<td></td>
<td>FT:</td>
</tr>
<tr>
<td>Address:</td>
<td></td>
<td></td>
<td>Relationship:</td>
</tr>
<tr>
<td>City:</td>
<td></td>
<td></td>
<td>State:</td>
</tr>
<tr>
<td>Home Telephone Number:</td>
<td>Work Telephone Number:</td>
<td>Family Dentist:</td>
<td></td>
</tr>
<tr>
<td>Family Physician:</td>
<td>Clinic:</td>
<td>Telephone Number:</td>
<td></td>
</tr>
<tr>
<td>Hospital:</td>
<td></td>
<td>Telephone Number:</td>
<td></td>
</tr>
<tr>
<td>Last Visit to Doctor:</td>
<td>Child's Height:</td>
<td>Child's Weight:</td>
<td></td>
</tr>
<tr>
<td>Does the Child Have any food, medication or environmental allergies:</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>If Yes, List Allergies:</td>
<td>Describe Allergy Reaction:</td>
<td>Usual Treatment:</td>
<td></td>
</tr>
</tbody>
</table>

**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):  

**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:  

[Form fields filled in with placeholder text]