CHILD INFORMATION SHEET

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
CHILDREN AND FAMILY SERVICES
SFN 845 (2-2020)

Every Early Childhood Program is required to have certain information on file. These requirements are set forth in the rules and regulations for Early Childhood Services as adopted by the North Dakota Department of Human Services. All information requested herein is required and shall be kept confidential.

Child's Name	Date Child Enrolled	Preferred or Nickname of Child	Date of Birth
Parent's Name	Home Telephone Number	Cell Phone Number	Work Telephone Number
Home Address			
Place of Employment			Hours of Work
Parent's Name	Home Telephone Number	Cell Phone Number	Work Telephone Number
Home Address			
Place of Employment			Hours of Work

EMERGENCY AUTHORIZATION

In case of an emergency and parents cannot be reached, who should be contacted?

Name	Relationship to Child	Work Telephone Number	Home Telephone Number
Name	Relationship to Child	Work Telephone Number	Home Telephone Number
Physician to Call in an Emergency			Clinic Telephone Number
Dentist to Call in an Emergency			Clinic Telephone Number

I hereby authorize the Early Childhood Program to secure emergency medical treatment for my child under the following conditions:

1. An emergency or unanticipated condition necessitates immediate action for the preservation of the life or health of the child, and
2. Reasonable attempts to contact me have failed.

Parent Signature	Date	Parent Signature	Date

AUTHORIZATION TO RELEASE CHILD

Unless otherwise authorized by you in writing, only the parent or legal guardian may pick up your child(ren) from the Early Childhood Program. List below any others you wish to authorize for this purpose.

Name	Relationship to Child	Telephone Number
Name	Relationship to Child	Telephone Number
Name	Relationship to Child	Telephone Number

These people are <u>NOT</u> allowed to pick up my child.

Name	Relationship to Child
Name	Relationship to Child

For Operator Use Only:

The identification of this child has been verified. As proof of identification, the child's parent has produced: ☐ Copy of Child's Birth Certificate ☐ Child's Passport ☐ Other _____
Signature of Operator

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