# DECLARATION OF GOOD HEALTH

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
FOSTER CARE/ADOPTION
SFN 972 (9-2019)

Clear Fields

**PURPOSE OF DECLARATION OF GOOD HEALTH:** The Declaration of good health is required for each individual(child and adult) in the applicant home. This does not include foster children. It is a requirement for licensure or approval to help assure the health, safety and well being of children placed in the foster home.

**PLEASE PROVIDE COMPLETE INFORMATION. IF AN EXPLANATION IS INDICATED, USE THE APPROPRIATE SPACE AND ATTACH ADDITIONAL SHEETS AS NECESSARY.**

For initial licensure only: Applicants must complete the Physical Exam Verification Form (SFN 974). A physical exam is not rquired during annual renewal and is not required at anytime for household members.

**IDENTIFYING INFORMATION**

| Name |
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**MEDICAL INFORMATION**

| Date of last physical exam | Clinic/Physician |
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The following conditions, when untreated or severe, can have an impact on the care giver's normal child rearing abilities. If you have a history of any of the following, please check and explain:

- ☐ Alcohol/other chemical dependency
- ☐ Cancer
- ☐ Chronic back pain
- ☐ Diabetes
- ☐ Emotional/psychological condition
- ☐ Hearing difficulties
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Migraine headaches
- ☐ Non-corrected vision
- ☐ Seizure disorder
- ☐ Tuberculosis (TB)
- ☐ Other - Please list _____

Explanation for any checks indicated above. Please include any limitations/adjustments needed for you to provide care to children:

List any prescribed medications (name, dosage, frequency):

If you have any condition or illness, other than listed and discussed above, that may interfere with your ability to provide foster care, please explain:

| Are your immunizations up to date? ☐ Yes ☐ No | If no, please explain: |
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**Additional information may be requested by the agency or the North Dakota Department of Human Services**

**THIS IS A PUBLIC DOCUMENT AND WILL BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST**

**CERTIFICATION:** I certify that the above information is true to the best of my knowledge and I grant permission for this information to be verified with the appropriate personnel or agency.

| Applicant Signature | Date |
|---|---|
| | |

**COPIES to:**

- ☐ Foster Parents
- ☐ Authorized Licensing Agent
- ☐ Licensing Agency-DHS