SPECIAL NEEDS SCREENING FORM

Purpose: To provide child and family program eligibility and background information; to assist with child's placement and obtain sponsor consent for access to emergency medical care; data required by EFMP. Policies shall be implemented to ensure that appropriate services are provided for children, youth, and teens with special needs. Such policies shall meet the requirement of the Rehabilitation Acts and the Department of Defense Directive 1020.1, Non Discrimination on the Basis of Handicap in Programs and Activities Assisted or Conducted by the Department of Defense.

Routine Uses: This information will be shared with members of the Special Needs Evaluation Review Team (SNERT) to assist with making an informed decision about your child's placement. Information is used for program admission to ensure staff training is pertinent to the child's needs. Information is furnished for the attending physician when it is necessary for a child to be taken to a medical facility by someone other than the parent.

Disclosure: Disclosure of information is voluntary; however, if information is not provided, individuals may not be allowed to participate in Children, Youth, and Teen programs. Please note any medication your child may take, or has taken consistently for the last six months.

Child's Name: _____ DOB: _____ Program: CYTP

Sponsor's Name: _____

Is child enrolled in the Exceptional Family Member Program (EFMP) (please circle) YES NO

PLEASE CHECK ALL THAT APPLY IF YOUR CHILD HAS BEEN DIAGNOSED WITH ANY OF THE FOLLOWING MEDICAL OR DEVELOPMENTAL CONDITIONS:

- ☐ Allergy (Food or Insect) Explain reaction: _____
- ☐ Allergy – Seasonal
- ☐ Apnea Monitor
- ☐ ADD or ADHD
- ☐ Asthma or RAD
- ☐ Autism/Pervasive Developmental Disorder
- ☐ Behavior Concerns (ODD, etc)
- ☐ Brittle Bones
- ☐ Cancer
- ☐ Cerebral Palsy/Loss of Mobility
- ☐ Cleft Lip and/or Palate (NOT repaired)
- ☐ Cystic Fibrosis
- ☐ Developmental Delays
- ☐ Down Syndrome
- ☐ Equipment Needs (G-tube, colostomy, O2, tracheotomy, Wheelchair, etc)
- ☐ Epilepsy/Seizures
- ☐ Genetic Disorders/ Congenital Anomalies
- ☐ Hearing Impaired
- ☐ Heart Conditions (congenital or acquired)
- ☐ Hydrocephalus/Macrocephaly
- ☐ Immune Deficiency
- ☐ Inflammatory Bowel Disease (Crohns, UC)
- ☐ Psychological Cond (Depression, OCD, etc)
- ☐ Orthopedic Impairment
- ☐ Premature Infant (<35 weeks)
- ☐ Spina Bifida
- ☐ Speech Delay
- ☐ Visually Impaired (not corrected by glasses)
- ☐ Other: _____

Routine Medication(s): _____

Required Special Care or Service(s): _____

- ☐ My child has **NO** special needs or diagnosed condition(s)

_____ _____

Parent Signature & Date CYTP Representative & Date