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 the Exceptional Family Member Program. 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 Inclusion Action Team (IAT) 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 Child and Youth Programs.

Child's Name: _____ DOB: _____

Sponsor's Name: _____

Routine Medication(s) taken consistently of the past 6 months:_____

Required Special Care or Service(s): _____

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

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

Check	Special Needs/Conditions	Comments
☐	*Allergy – Food/ Medication	
☐	*Allergy – Environmental/Insect	
☐	ADD/ADHD	
☐	*Asthma or RAD	
☐	Autism/Pervasive Developmental Disorder	
☐	Behavior Concerns (ODD, etc)/ Psychological Concerns: (Depression, OCD)	
☐	Developmental Delays/ Speech Delays	
☐	Epilepsy/ Seizures	
☐	Medical Equipment Needs (G-tube, tracheotomy, Wheelchair, etc)	
☐	Genetic Disorder (please list):	
☐	Other (please list):	

***PHYSICIAN SIGNED DOCUMENTATION WILL BE REQUIRED PRIOR TO START DATE.**