CHILDREN, YOUTH & TEEN PROGRAMS
Statement of Special Needs, Medical or Developmental Conditions

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; and to provide 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 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, Youth and Teen Programs. Please note any medication your child may take, or has taken consistently in the last six months.*

Child/Youth Name (Last, First)	Sponsor Name	Date of Birth	Program (Circle)
			CDC SAC Youth &Teen

Please check (✓) if your child has any of the following:

	Asthma *Please indicate severity/triggers:*
	Apnea
	Autism *(to include PDD-nonspecific, Asperger's Syndrome, or any Pervasive Developmental Disorder)*
	Allergies *(severity allergies to bee stings, severe environmental or severe food allergies; severe is defined as "life threatening conditions occur when contact with allergen is made")*
	Any chromosomal disorder *(such as Down Syndrome, Velo-Cardio Facial Syndrome, X-chromosome disorders or a mutation of any chromosome)*
	Seizure Disorder *Please indicate type:*
	Diabetes
	(Infants Only) Prematurity, as defined as born before 36 weeks gestation
	Developmental Disability *(mental retardation)*
	Developmental Delay *Please check all that apply:* _____ communication or speech delay _____ emotional delay _____ motor/physical skill delay
	Blood disorder *(such as hemophilia)* Note: If child is HIV positive, do not indicate it on this form. To safe guard your child's confidentiality, you may choose to reveal your child's HIV status to the director. This will aid the program in providing services to safeguard you child's health.
	Attention Deficit Disorder with/without Hyperactivity *(ADD/ADHD)*

	Severe Behavior Disorder *(SBD)*
	Obsessive Compulsive Disorder *(OCD)*
	Other mental health condition *(such as paranoia or schizophrenia)*
	Hard or hearing or deaf
	Blind
	(For toddlers, preschoolers and school-aged children) Unable to walk, including children using a wheelchair
	Suffered several physical trauma *(due to incidents such as, but not limited to, automobile accident, a severe fall, physical abuse)*
	Suffered severe emotional trauma *(due to incidents such as, but not limited to, any type of abuse, death of a parent or sibling)*
	Digestive Disorder *Specify:*
	Respiratory Disorder *Specify:*
	Chronic Heart Condition
	Disorder of the spine or skeletal system *(such as scoliosis)*
	Missing limb
	Other special needs or medical conditions not listed. *Specify:*
	Routine Medications *Specify:*
	Required special care or services *Specify:*
	My child has NO special needs or diagnosed condition(s).

If your child has been identified with any special needs, are you currently enrolled in the Exceptional Family Member Program? _____ YES _____ NO

I have disclosed, to the best of my ability, any special needs, medical, or developmental conditions my child may have.

Sponsor's/Parent's Signature: _____ Date_____