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 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 in the last six months.

<table>
<thead>
<tr>
<th>Child’s Name (Last, First)</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sponsor’s Name (Last, First)</td>
<td>Program (Circle)</td>
</tr>
<tr>
<td>CDC</td>
<td>SAC</td>
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</tbody>
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Please check (√) if your child has any of the following:

- **Asthma**
- **Apnea**
- **Autism** (to include PDD-non specific, Asperger’s Syndrome, or any Pervasive Developmental Disorder)
- **Allergies** (severe 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**
- **Diabetes**
- (For 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 safeguard 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 your child’s health.

Attention Deficit Disorder with or without Hyperactivity (ADD/ADHD)

Severe Behavior Disorder (SBD)

Obsessive Compulsive Disorder (OCD)

Other mental health condition such as Paranoia or Schizophrenia

Hard of hearing or deaf

Blind

(For Toddlers, Preschoolers and School-agers) Unable to walk (including children using a wheel chair)

Suffered severe 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 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.

Please specify

Routine Medications, specify

Required Special Care or Service(s)

Please 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.

_______________________________________________
Parent’s Signature

_______________________________________________
Date

_______________________________________________
CYTP Representative

_______________________________________________
Date