## Lejeune - New River Child & Youth Programs
## Medical & Developmental History Screening Tool

**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 and youth 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 Program. Please note any medication your child may take, or has taken consistently in the last six months.

### General Information

| Child/Youth Name | | Date of Birth | |
|---|---|---|---|
| Sponsor Name | | | |

Is your child enrolled in the Exceptional Family Member Program (EFMP)? Yes ☐ No ☐

### If a medical or developmental condition has been diagnosed for your child, please check all that apply:

☐ Allergy (Food or Insect) Explain type / reaction: **(Complete Adjunct Allergy Form)**

☐ Allergy – Seasonal
☐ Apnea Monitor
☐ ADD or ADHD
☐ Asthma or RAD **(Complete Adjunct Asthma/ RAD Form)**
☐ Autism/ Pervasive Developmental Disorder
☐ Behavior Concerns (ODD, etc.)
☐ Brittle Bones
☐ Cancer
☐ Cerebral Palsy / Loss of Mobility
☐ Other (Explain):
☐ Cleft Lip and/or Palate (not repaired)
☐ Cystic Fibrosis
☐ Developmental Delays
☐ Down Syndrome
☐ Equipment Needs (g-tube, colostomy, Oxygen, Tracheotomy, Wheelchair, etc.)
☐ Genetic Disorder/Congenital Anomalies
☐ Hearing Impaired
☐ Heart Conditions (Congenital or Acquired)
☐ Hydrocephalus / Macrocephaly
☐ Immune Deficiency
☐ Inflammatory Bowel Disease (Crohns, UC)
☐ Orthopedic Impairment
☐ Premature Infant (< 35 weeks)
☐ Psychological Condition (Depression, OCD, etc.)
☐ Seizure Disorder **(Complete Adjunct Seizure Form)**
☐ Spina Bifida
☐ Speech Delay
☐ Visually Impaired (Not Corrected by Glasses)

### Medications and Special Care or Services

Does your child take any routine medications? No ☐ Yes ☐ If yes, list:

Does your child require any special care or services? No ☐ Yes ☐ If yes, explain:

### Parent Signature

| Parent/Guardian Signature | Date |
|---|---|

### CYP Representative Signature

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

LEJEUNE-NEW RIVER

Revised Jan 2018