

THIS IS A MANDATORY FORM

SPECIAL NEEDS/CHILD PLACEMENT QUESTIONNAIRE

Welcome to Ft. Leavenworth Child & Youth Services! If your child should have a special need, prior knowledge will allow us to make appropriate adjustments to our program and provide training to the staff before your child's first day.

Children with Special Needs must attend a Special Needs Resource Team (SNRT) Meeting before enrollment in any CYS program. These are held on the 1st Wednesday of every month. Failure to attend this meeting will result in suspension of services. Patron must provide all medical documentation for child's condition.

Child's Name _____ Date of Birth _____

Does your child have any of the following conditions?	YES	NO	YES	NO
1. Developmental Delays. Explain below.			9. Asthma/Respiratory Problems. Explain below.	
2. Visual Problems/Blindness. (Do not check this box if your child only wears glasses)			10. Heart Problems. (Do not mark this box if your child has a functional or innocent heart murmur)	
3. Hearing Problems. Explain below.			11. Speech/Language Delay. Explain below.	
4. Physical Disability. Explain below.			12. Behavioral/Conduct Concerns. Explain below.	
5. Sickle Cell Disease. (Do not mark if sickle cell trait)			13. Diabetes.	
6. Kidney Problems. Explain below.			14. Attention Deficit/Hyperactivity (ADD/ADHD)	
7. Epilepsy/Seizures			15. Food Allergies/Intolerances. Explain below.	
8. Autism/PDD			16. Other(s) Please Specify:	

Is your child taking medication for his/her condition. If yes, please specify:

Is your child receiving any services from EDIS (formally EFMD) Early Intervention, CAPS or pediatric Behavioral Medicine?
 ___YES ___NO If yes, which school or agency?

Is your child enrolled in a Developmental Preschool or have an IEP or IFSP ___YES ___NO. If yes, please explain:

Is your child enrolled in an Exceptional Family Member Program (EFMP)? ___YES ___NO. If yes, please explain:

Does your child have any special dietary requirements? ___YES ___NO. If yes, please explain:

I give permission for my child's name with a list of food allergies to be posted in the food preparation area and classroom YES NO

Use this block for explanations for questions 1-16.

FAILURE TO DISCLOSE ANY SPECIAL NEEDS WILL RESULT IN SUSPENSION OF SERVICES

Signature of Parent/Sponsor/Guardian

Home Phone/Duty Phone

Print Name (state rank if applicable)

(OFFICE USE ONLY)

History of Special Need/Medical Condition: (telephone contact indicate date and time) _____

SNRT Date/Time Scheduled _____

Parent given SNRT Notification Letter ___ YES Date _____