DEPARTMENT OF AIR FORCE

CHILD AND YOUTH PROGRAMS

**CHILD AND YOUTH PROGRAM**
**HEALTH ASSESSMENT**

Child's Name _____

**IDENTIFICATION OF MEDICAL AND/OR DIETARY NEEDS**

1. Is there any information we need to know to support your child's medical needs? Yes☐ No☐
   If "Yes", please briefly describe.

2. Does your child have any allergies or allergic reactions? Yes☐ No☐
   If "Yes". please list the allergies and corresponding reactions.

3. Does your child require emergency response medication? Yes☐ No☐
   If "Yes", please describe your child's emergency response medication.

4. Will your child need to take medication for any ongoing medical condition (non-emergency) when in care? (This does not include medication for temporary needs such as an antibiotic.) Yes☐ No☐
   If ''Yes", please describe your child's ongoing medication.

5. Has your child had a vision and hearing screen? (For CDC only) Yes☐ No☐
   If "Yes", please describe the results.

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## OTHER NEEDS REQUIRING ASSISTANCE

6. Does your child require any accommodation to participate in CYP (e.g., alternative communication, physical, sensory or materials adaptations)? Yes☐ No☐
   If "Yes," please describe the accommodations.

## EARLY INTERVENTION AND SPECIAL EDUCATION

7. Is your child receiving services through an Individual Family Service Program (IFSP) or Individualized Education Program (IEP)? Yes☐ No☐

## EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) ENROLLMENT

8. Is your child enrolled in EFMP? Yes☐ No☐

I acknowledge that all the above information is true and accurate. I understand that if there are changes in my child's health or developmental needs that will require additional assistance in CYP, I must notify CYP. Changes to my child's health information may require additional medical documentation and meeting with the installation Inclusion Action Team (IAT).

_____
Sponsor's Signature and Date

_____
Program Manager's Signature and Date

This Health Assessment must be reviewed by the parent(s) each year during the annual registration process. If there are no changes to the made, parents may simply initial and date below. If there are changes to be made, a new Health Assessment is required to be completed.

_____ _____ _____
Sponsor's initials and Date Sponsor's initials and Date Sponsor's initials and Date