JBSA Child And Youth Program

3

MEDICAL CONDITIONS REVIEW

To be completed by medical provider (Physician, Nurse Practitioner, or Physician's Assistant)
Providers please check all that apply and provide details as needed

Child's Name:	☐ **Male** ☐ **Female**	**Date of Birth:** (***MMDDYYYY***)

CHRONIC CONDITIONS

☐ **Atopic Disease (food allergy/eczema)**	☐ **Blindness/Vision Condition**	☐ **Autism Spectrum**
☐ **Seasonal Allergies (Allergic Rhinitis)**	☐ **Heart Condition**	☐ **ADHD** ☐ **ADD**
☐ **Asthma (reactive airway disease)**	☐ **Kidney Condition**	☐ **Anxiety**
☐ **Seizure Disorder**	☐ **Speech Concern**	☐ **Behavioral Concerns**
☐ **Epilepsy** ☐**Febrile Seizure**	☐ **Deafness/Hearing Condition**	☐ **Other**
☐ **Diabetes**	☐ **Developmental Delay**	
☐ **Cerebral Palsy**		

Provide Details for checked items (month and year with current status):

DIETARY AND FEEDING CONCERNS

List Food Allergies on the Special Diet Statement (Please indicate the appropriate substitution on page 2).

☐ **Food Allergies** ☐ **Special Diet Statement Provided**

☐ **Feeding Concerns** ☐ **Swallowing Difficulty/Aspiration risk**

Provide details for checked items:

DAILY MEDICATION TREATMENT

Daily Medications:	**Dosage:**	**Time/Frequency:**

Version 3- Approved by JBSA, CYP Flight Chief, July 2016

Child's Name: _____ Date of Birth: _____

EMERGENCY MEDICATION REQUIRED

List any Emergency Medications Required.

Medication:	Dosage:	Time/Frequency:

EMERGENCY MEDICAL ACTION PLANS REQUIRED

Check the Applicable Medical Action Plans

☐ **Allergy Medical Action Plan** ☐ **RESP MAP or Asthma Action Plan. (Please list triggers on MAP)**

☐ **Seizure Medical Action Plan** ☐ **Diabetes Medical Action Plan** ☐ **Other:_____**

DEVELOPMENTAL CONCERNS

Developmental concerns ☐ **Yes** ☐ **No**
Provide explanation:

The child functions at the developmental level of _____months/years.
Special Accommodations are required: ☐ **Yes** ☐ **No**

If Yes describe the required accommodation:

DEVELOPMENTAL PLANS

The child has the following Plans available:
☐ **Individual Education Plan (IEP)** ☐**Individualized Family Service plan (IFSP)** ☐**504 plan**
Comments:

THERAPY PROVIDED

Therapy Provided:			
☐ Occupational Therapy (OT): frequency _____	☐ school/program	☐ home	☐ clinical setting
☐ Physical Therapy (PT): frequency_____	☐ school/program	☐ home	☐ clinical setting
☐ Speech Therapy (ST): frequency _____	☐ school/program	☐ home	☐ clinical setting

PHYSICAL ADAPTATIONS

List any physical adaptations or special equipment required:

Provider's Stamp:	Signature:	Date: (*MMDDYYYY*)