



Form A *(to be completed by parent/guardian)*

Child and Youth Program Joint Base Elmendorf-Richardson Inclusion Action Plan

PART A. To be completed by the parents/guardians.

Child's name: _____ DOB: _____ Date: _____

Circle one: Hourly Care - Full Time Care - Part Day Preschool - Before and After School – Youth-Sports

Sponsor's name: _____ Email _____

Spouses' name: _____ Email _____

Home phone: _____ Cell phone: _____

Does your child have allergies, developmental delays, behavioral concerns or any other medical condition?

Check a box. **Yes** (Proceed to Part B). **No** (DO NOT PROCEED) _____
 (Parent/Guardian signature)

PART B. Parents/guardians, check the appropriate box or boxes, get the appropriate paperwork and have it signed by a physician.

CHRONIC CONDITIONS		
<p><u>Form D Required</u> <input type="checkbox"/> Respiratory (Asthma)</p> <p><u>Form E Required</u> <input type="checkbox"/> Seizure Disorder</p> <p><u>Form F Required</u> <input type="checkbox"/> Diabetes</p>	<p><u>Form B Required</u></p> <p><input type="checkbox"/> Blindness/Vision Condition <input type="checkbox"/> Heart Condition <input type="checkbox"/> Kidney Condition <input type="checkbox"/> Deafness/Hearing Condition <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Atopic Disease</p>	<p><u>Form B Required</u></p> <p><input type="checkbox"/> Speech Concern <input type="checkbox"/> Autism Spectrum <input type="checkbox"/> ADHD ADD <input type="checkbox"/> Anxiety <input type="checkbox"/> Behavioral Concerns <input type="checkbox"/> Other _____ _____ _____</p>
<p>Provide details for checked items (month and year with current status) :</p> 		
DIETARY AND FEEDING CONCERNS		

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Form C Required

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Special Diet Statement Provided | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Feeding Concerns | <input type="checkbox"/> Swallowing Difficulty/Aspiration risk | _____ |

Provides details for checked items: _____

Does your child/youth receive special services/therapies? **Yes** **No** Please specify:

Is your child/youth enrolled in the EFMP? **Yes** **No** Please specify

I acknowledge the information about my child will be shared with the Inclusion Action Team, Child and Youth Program personnel, and/or medical professionals in order to receive individualized recommendation for accommodations and support.

Parent's signature

Date