## Child’s Name:

- [ ] Male
- [ ] Female

## Date of Birth: (MMDDYYYY)

### CHRONIC CONDITIONS

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

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

<table>
<thead>
<tr>
<th>Daily Medications:</th>
<th>Dosage:</th>
<th>Time/Frequency:</th>
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MEDICAL CONDITIONS REVIEW CONTINUED

Child’s Name: _________________________________________________     Date of Birth: ______________

EMERGENCY MEDICATION REQUIRED
List any Emergency Medications Required.

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<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Time/Frequency</th>
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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 ____________
- [ ] Physical Therapy (PT): frequency ____________
- [ ] Speech Therapy (ST): frequency ____________

- [ ] school/program  
- [ ] home  
- [ ] clinical setting

- [ ] school/program  
- [ ] home  
- [ ] clinical setting

- [ ] school/program  
- [ ] home  
- [ ] clinical setting

PHYSICAL ADAPTATIONS
List any physical adaptations or special equipment required:

Provider’s Stamp: ____________________________  Signature: ____________________________  Date: (MMDDYYYY)