INSTRUCTIONS FOR COMPLETING DD FORM 2792,
EXCEPTIONAL FAMILY MEMBER
MEDICAL AND EDUCATIONAL SUMMARY

GENERAL.

The DD Form 2792 and attached addenda are completed to identify a family member with special medical or educational needs. Section I is completed by the sponsor or spouse and the medical provider or EFM Screening Coordinator. The addenda are completed only if noted in Item 9. The EFM Screening Coordinator and sponsor sign Items 10a and 10b only after all addenda have been completed and the form reviewed for completeness and accuracy.

Section I, Items 1 - 8 *(Completed by Sponsor or Spouse)*

Item 1a. Application Status *(X one).*
Initial Screening - First Exceptional Family Member (EFM) application for the family member noted, or
Updated Information - Update to a previous EFM evaluation for the family member noted.

Item 1b. Family Status. Additional Family Member - X if there is another family member who has been identified as an EFM.

Items 2a. - e. All items refer to sponsor. Self-explanatory.

Item 3. Answer Yes if the sponsor were assigned to current duty station for humanitarian or compassionate reasons, e.g., to ensure that a family member receives health care at a major medical treatment facility.
Enter No if the sponsor is not currently assigned for humanitarian reasons.

Item 4. Answer Yes if both spouses are on active duty; otherwise answer No. If Yes, complete Items 4a. - c.

Items 4a. - c. Self-explanatory.

Item 5a. Exceptional family member name. Enter name for the family member for whom this form will be completed.

Item 5b. Relationship to sponsor. (Son, daughter, spouse, etc.)

Item 5c. Date of birth. Self-explanatory.

Item 6. Primary health care system. Military treatment facility - services provided by a uniformed or civilian provider at the military treatment facility. TRICARE/Non-MTF - if the provider is a civilian contract provider who provides services under one of the TRICARE options. State - if the services are provided under Medicaid or another state program. Other - if the sponsor is civilian.

Item 7. DEERS enrollment. Military only. Self-explanatory.

Item 8. Self-explanatory.

Item 9. Required addenda. *(Completed by provider and/or Screening Coordinator.)* Mark (X) those addenda that require completion based on a review of medical records and/or screening of a family member.

Item 10a. Sponsor name, signature, date. **Sponsor must ensure that all forms are complete and attached before signing.**

Item 10b. EFM Screening Coordinator name, signature, date. **Coordinator must ensure that all forms are complete and attached before signing.**

INSTRUCTIONS FOR COMPLETING DD FORM 2792 ADDENDA

ADDENDUM A - MEDICAL SUMMARY.

Complete this addendum if indicated in Item 9a. **Sponsor must sign release authorization before this addendum is completed** *(Items 2a. - c.)*.

Items 1a. - c. Provider name, address, telephone number. Self-explanatory.

Items 2a. - c. Sponsor/spouse authorization. Self-explanatory. **Must be completed and signed before addenda are completed by providers.**

Item 3a. Diagnoses. Enter the diagnosis(es), one per line.

Item 3b. Severity. Enter severity of the diagnosis(es).

Item 3c. ICD or DSM. Enter ICD-9-CM or DSM IV designations.

Item 3d. Medications and therapies. Self-explanatory.

Item 3e. Enter the number of visits, hospitalizations, etc., for the last 6 months.

Items 4 - 9. Self-explanatory.

Item 10. Comments. Enter any additional information to describe this individual's medical needs.

Item 11. (1) Minimum health care specialty. Indicate with an X those specialists required by the patient.
(2) Frequency of care. Enter A - Annually; B - Biannually; Q - Quarterly; M - Monthly; or W - Weekly for each specialist indicated.

Item 12. Name and signature of the provider completing this addendum, and date addendum was signed.

ADDENDUM A-1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY.

This addendum is completed only if indicated by the Screening Coordinator in Item 9.

Items 1a. - c. Self-explanatory.

Items 2a.- c. Self-explanatory.

Items 3a.- e. Self-explanatory.

Items 4 - 6. Self-explanatory.

ADDENDUM A-2 - MENTAL HEALTH SUMMARY.

This addendum is completed only if indicated by the Screening Coordinator in Item 9a.

Items 1a.-c. Self-explanatory.

Items 2a.-c. - 5a.-b. Self-explanatory.

Item 6. Cooperation. Describe patient (guardian if a minor) cooperation with treatment.

Items 7 - 8. Self-explanatory.

Item 9. Comments. Include any additional information that would assist in determining necessary treatment.

ADDENDUM B - SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

This addendum is completed if indicated by the Screening Coordinator in Item 9. The form is completed by school or early intervention staff. **Only this educational addendum should be provided to school or early intervention staff. Do not include medical summary or addenda.**

Item 1a. Release of information. Sponsor name. Self-explanatory. Completed by sponsor or spouse.

Item 1b. Sponsor SSN. Enter the sponsor's social security number.

Item 1c. Sponsor/Spouse signature. Self- explanatory. **Sign and date before providing form to school or early intervention program.**

Item 1d. Date signed. Self-explanatory.

Items 2a.-e. Child information. Self-explanatory. Completed by sponsor or spouse.

Items 3a.-e. EIP/School information. Completed by EIP or school personnel. Mark (X) Yes or No for each item. **If Yes is marked in any Item 3a.-d., remainder of form must be completed.**

Items 4a.-b. Eligibility criteria. Mark only one.

Item 5. Severity. Mark only one.

Item 6. Provider/school official information. Self-explanatory.

EXCEPTIONAL FAMILY MEMBER MEDICAL AND EDUCATIONAL SUMMARY

(To be completed by service member or civilian employee)
(Read Instructions before completing this form.)

Form Approved
OMB No. 0704-0411
Expires Feb 28, 2003

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PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 3013, 5013, and 8013; 20 USC 921 - 932; and 1400 et seq.; DoD Instruction 1342.12, *(Provision of Early Intervention and Special Education to Eligible DoD Dependents in Overseas Areas)*, March 12, 1996); DoD Instruction 1010.13 *(Provision of Medically Related Services to Children Receiving or Eligible to Receive Special Education in DoD Dependents Schools Outside of the United States*), August 28, 1986); EO 9397.

PRINCIPAL PURPOSE(S): Information will only be used by personnel of the Military Departments to evaluate and document the medical and/or special educational needs of family members. This information will enable: (1) Military assignment personnel to match the needs of family members against the availability of special education and medical services; and (2) Civilian personnel offices to determine the availability of special education and medical services to meet the needs of dependent children and the medical needs of family members of DoD and Military Department civilian employees.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary; however, failure to respond will preclude: (1) Military Services from enrolling service members in the EFMP. A service member's refusal to provide information may preclude successful processing of an application for family travel/command sponsorship; and (2) Civilian personnel offices from performing required aspects of processing of DoD or Military Department civilian employees with family members with special needs. A civilian employee's refusal to provide information may result in employment in a location that lacks required special education or medical services.

1a. APPLICATION STATUS *(X one)*				**b. FAMILY STATUS**	
	INITIAL SCREENING		**UPDATED INFORMATION**		**ADDITIONAL FAMILY MEMBER HAS BEEN IDENTIFIED**

SECTION I - IDENTIFICATION

2.a. SPONSOR NAME *(Last, First, Middle Initial)*	**b. SSN**	**c. RANK OR GRADE**
d. BRANCH OF SERVICE *(Military only)*	**e. DESIG/NEC/MOS/AFSC** *(Military only)*	
f. HOME ADDRESS *(Street, Apartment Number, City, State, ZIP Code)*	**g. DUTY STATION ADDRESS**	
h. HOME TELEPHONE NUMBER *(Include Area Code)*	**i. DUTY TELEPHONE NUMBER** *(Include Area Code)* **(1) COMMERCIAL**	**(2) DSN**

3. ARE YOU CURRENTLY ON HUMANITARIAN ASSIGNMENT? *(Military only) (X one)*		**YES**		**NO**	
4. ARE BOTH SPOUSES ON ACTIVE DUTY? *(X one)*		**YES**		**NO**	**N/A**

(If Yes:) **a. SPOUSE'S NAME** *(Last, First, Middle Initial)*	**b. RANK/RATE**	**c. SSN**
5.a. EXCEPTIONAL FAMILY MEMBER NAME *(Last, First, Middle Initial)*	**b. RELATIONSHIP TO SPONSOR**	**c. DATE OF BIRTH** *(YYYYMMDD)*

6. PRIMARY HEALTH CARE SYSTEM USED BY FM *(X one)*				**7. IS FAMILY MEMBER ENROLLED IN DEERS** *(Military only) (X one)*		
	MILITARY TREATMENT FACILITY		**STATE**		**YES**	**IF YES, UNDER WHAT SSN:** _____
	TRICARE/NON-MTF		**OTHER**		**NO**	**FAMILY MEMBER PREFIX** _____

PATIENT NAME	SPONSOR SSN	FAMILY MEMBER PREFIX

8. DOES FAMILY MEMBER RESIDE WITH SPONSOR *(X one)*

☐ **YES**

☐ **NO. IF NO, PROVIDE ADDRESS OF FAMILY MEMBER** *(Include ZIP Code)* **AND EXPLAIN WHY.**

9. REQUIRED ADDENDA

a. REQUIRED ADDENDA *(X as necssary)*

☐ **ADDENDUM A - MEDICAL SUMMARY**

☐ **ADDENDUM A-1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY**

☐ **ADDENDUM A-2 - MENTAL HEALTH SUMMARY**

☐ **ADDENDUM B - EARLY INTERVENTION/SPECIAL EDUCATION SUMMARY** *(Most recent IEP or IFSP must be attached if the child requires special services.)*

10. CERTIFICATION

We certify that the information submitted on the EFM Medical and Educational Summary form and the addenda checked above are complete and accurate.

a. SPONSOR

(1) PRINTED NAME	(2) SIGNATURE	(3) DATE *(YYYYMMDD)*

b. EFM SCREENING COORDINATOR

(1) PRINTED NAME	(2) SIGNATURE	(3) DATE *(YYYYMMDD)*

(4) MILITARY TREATMENT FACILITY ADDRESS *(Include ZIP Code)*	(5) TELEPHONE NUMBER *(Include area code)*

ADDENDUM A - MEDICAL SUMMARY

PATIENT NAME	SPONSOR SSN	FAMILY MEMBER PREFIX

PART A - RELEASE AUTHORIZATION *(To be completed by service member/spouse/civilian employee)*

1a. PROVIDER NAME

b. ADDRESS *(Include ZIP Code)*

c. TELEPHONE NUMBER *(Include Area Code)*

(1) COMMERCIAL	(2) DSN

2. SPONSOR/SPOUSE AUTHORIZATION

I hereby authorize the above named provider or his or her agent to release information in this Medical and Educational Summary for the family member named below to Exceptional Family Member Program and related officials. I understand the information will only be used for the purpose of evaluating and determining necessary health-related services for

______________________________ , ______________________________

(Name of Family Member) *(Relationship to Sponsor)*

a. PRINTED NAME *(Last, First, Middle Initial)*	b. SIGNATURE	c. DATE *(YYYYMMDD)*

PART B *(To be completed by provider)*

3. DIAGNOSIS(ES) Please complete as accurately as possible using ICD-9-CM or DSM IV.

a. CURRENT ACTIVE DIAGNOSIS	b. SEVERITY: A - MILD B - MODERATE C - SEVERE	c. ICD OR DSM	d. MEDICATIONS AND SPECIAL THERAPIES	e. COMPLETE FOR THE LAST 6 MONTHS:	
					(1) NUMBER OF OUTPATIENT VISITS
					(2) NUMBER OF ER VISITS
					(3) NUMBER OF HOSPITALIZATIONS
					(4) NUMBER OF ICU ADMISSIONS
					(1) NUMBER OF OUTPATIENT VISITS
					(2) NUMBER OF ER VISITS
					(3) NUMBER OF HOSPITALIZATIONS
					(4) NUMBER OF ICU ADMISSIONS
					(1) NUMBER OF OUTPATIENT VISITS
					(2) NUMBER OF ER VISITS
					(3) NUMBER OF HOSPITALIZATIONS
					(4) NUMBER OF ICU ADMISSIONS
					(1) NUMBER OF OUTPATIENT VISITS
					(2) NUMBER OF ER VISITS
					(3) NUMBER OF HOSPITALIZATIONS
					(4) NUMBER OF ICU ADMISSIONS

4. PROGNOSIS *(Include expected length of treatment, required participation of family members, and if treatment is ongoing)*

5. TREATMENT PLAN *(Medical, mental health, surgical procedures or therapies planned over the next three years)*

6. ARTIFICIAL OPENINGS/PROSTHETICS *(e.g., gastrostomy, tracheostomy, VP shunts, artificial limbs)*

☐ YES IF YES, SPECIFY:

☐ NO

ADDENDUM A - MEDICAL SUMMARY *(Continued)*

PATIENT NAME	SPONSOR SSN	FAMILY MEMBER PREFIX

7. HISTORY OF CANCER OR LEUKEMIA

☐ **YES** **IF YES, SPECIFY PROJECTED TREATMENT NEEDS:**

☐ **NO**

8. ENVIRONMENTAL/ARCHITECTURAL CONSIDERATIONS *(e.g., limited steps, complete wheelchair accessibility, air conditioning)*

☐ **YES** **IF YES, SPECIFY:**

☐ **NO**

9. ADAPTIVE EQUIPMENT/SPECIAL MEDICAL EQUIPMENT *(X as applicable)*

☐ **APNEA HOME MONITOR**	☐ **OTHER** *(Specify)*
☐ **HOME NEBULIZER**	
☐ **WHEELCHAIR**	
☐ **SPLINTS, BRACES, ORTHOTICS**	
☐ **HEARING AIDS**	
☐ **HOME OXYGEN THERAPY**	
☐ **HOME VENTILATOR**	

10. COMMENTS *(Enter additional information to describe this individual's medical needs.)*

ADDENDUM A - MEDICAL SUMMARY *(Continued)*

PATIENT NAME	SPONSOR SSN	FAMILY MEMBER PREFIX

PART C *(To be completed by provider)*

11. MINIMUM HEALTH CARE SPECIALTY REQUIRED FOR CARE

(1) CARE PROVIDER *(X as appropriate) (Specify if pediatrics sub-specialist)*		(2) FREQUENCY*	(1) CARE PROVIDER *(X as appropriate) (Specify if pediatrics sub-specialist)*		(2) FREQUENCY*
	a. ALLERGIST			dd. PEDIATRICIAN	
	b. AUDIOLOGIST			ee. PEDODONTIST	
	c. CARDIOLOGIST			ff. PHYSIATRIST	
	d. CARDIOLOGIST - PEDIATRIC			gg. PHYSICAL THERAPIST	
	e. DERMATOLOGIST			hh. PHYSICAL THERAPIST/PEDIATRIC	
	f. DEVELOPMENTAL PEDIATRICIAN			ii. PODIATRIST	
	g. DIALYSIS TEAM			jj. PSYCHIATRIST	
	h. DIETARY/NUTRITION SPECIALIST			kk. PSYCHIATRIST/CHILD	
	i. ENDOCRINOLOGIST			ll. PSYCHOLOGIST	
	j. FAMILY PRACTITIONER			mm. PSYCHOLOGIST/CHILD	
	k. GASTROENTEROLOGIST			nn. PULMONOLOGIST	
	l. GENERAL MEDICAL OFFICER			oo. RESPIRATORY THERAPIST	
	m. GYNECOLOGIST			pp. RHEUMATOLOGIST	
	n. HEMATOLOGIST/ONCOLOGIST			qq. RHEUMATOLOGIST/PEDIATRIC	
	o. HEMATOLOGIST/ONCOLOGIST/PEDIATRIC			rr. SOCIAL WORKER	
	p. IMMUNOLOGIST			ss. SPEECH AND LANGUAGE PATHOLOGIST	
	q. INTERNIST			tt. SURGEON - CARDIAC/THORACIC	
	r. NEPHROLOGIST			uu. SURGEON - GENERAL	
	s. NEPHROLOGIST/PEDIATRIC			vv. SURGEON - NEURO	
	t. NEUROLOGIST			ww. SURGEON - ORAL	
	u. NEUROLOGIST/PEDIATRIC			xx. SURGEON - ORTHOPEDIC - ADULT	
	v. NUCLEAR MEDICAL PHYSICIAN			yy. SURGEON - ORTHOPEDIC - CHILD	
	w. OCCUPATIONAL THERAPIST			zz. SURGEON - OTORHINOLARYNGOLOGIST	
	x. OCCUPATIONAL THERAPIST/PEDIATRIC			aaa. SURGEON - PEDIATRIC	
	y. OPHTHALMOLOGIST			bbb. SURGEON - PLASTIC	
	z. OPHTHALMOLOGIST/PEDIATRIC			ccc. TRANSPLANT TEAM	
	aa. ORTHODONTIST			ddd. UROLOGIST	
	bb. OTORHINOLARYNGOLOGIST			eee. OTHER *(Describe)*	
	cc. PAIN CLINIC				

***INDICATE THE FREQUENCY OF CARE: A - ANNUALLY B - BIANNUALLY Q - QUARTERLY M - MONTHLY W - WEEKLY**

EXAMPLE:

X	a. ALLERGIST	Q	X	nn. RESPIRATORY THERAPIST	W

12.a. PROVIDER NAME	b. SIGNATURE	c. DATE *(YYYYMMDD)*
		

ADDENDUM A-1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY *(To be completed by provider)*

1a. PATIENT NAME	b. SPONSOR SSN	c. FAMILY MEMBER PREFIX

2.a. PROVIDER NAME *(PCM or specialty provider)*	b. SIGNATURE	c. DATE *(YYYYMMDD)*

3. MEDICATION HISTORY

a. PAST	b. PRESENT	c. MEDICATION	d. DOSAGE	e. FREQUENCY

4. HISTORY ASSOCIATED WITH ASTHMA ATTACKS *(X as applicable)*

YES	NO	
		a. ARE THERE ANY TRIGGERS FOR THE FAMILY MEMBER'S ASTHMA ATTACKS *(stress, environmental, exercise)*?
		b. DOES THE FAMILY MEMBER ROUTINELY *(greater than 10 days per month/four months per year)* USE INHALED ANTI-INFLAMMATORY AGENTS AND/OR BRONCHODILATORS?
		c. HAS THE FAMILY MEMBER TAKEN ORAL STEROIDS DURING THE PAST YEAR *(prednisone, prednisolone)*? IF YES, NUMBER OF DAYS IN PAST YEAR:
		d. HAS THE FAMILY MEMBER EVER EXPERIENCED UNCONSCIOUSNESS OR SEIZURES ASSOCIATED WITH ASTHMA ATTACKS?
		e. HAS THE FAMILY MEMBER REQUIRED AN URGENT VISIT TO THE ER OR CLINIC FOR ACUTE ASTHMA DURING THE PAST YEAR?
		f. HAS THE FAMILY MEMBER BEEN HOSPITALIZED FOR PULMONARY DISEASE *(pneumonia, bronchitis, bronchiolitis, croup, RSV)* DURING THE PAST YEAR?
		g. DOES THE FAMILY MEMBER HAVE A HISTORY OF ONE OR MORE HOSPITALIZATIONS FOR ASTHMA RELATED CONDITIONS WITHIN THE PAST 5 YEARS?
		h. HAS THE FAMILY MEMBER REQUIRED MECHANICAL VENTILATION *(Intubation/use of respirator)* DURING THE PAST 3 YEARS?
		i. DOES THE FAMILY MEMBER HAVE A HISTORY OF INTENSIVE CARE ADMISSIONS?

j. HOW MANY DAYS HAS THE FAMILY MEMBER MISSED SCHOOL/WORK/PLAY DUE TO ASTHMA-RELATED PROBLEMS *(including visits to the physicians)* DURING THE PAST YEAR?

5. DISRUPTION OF ACTIVITY. How often does asthma disrupt the following activities? *(X as applicable)*

(1) ACTIVITY	(2) NEVER A PROBLEM	(3) 2 TIMES A YEAR OR LESS	(4) 3 - 7 TIMES A YEAR	(5) 8 - 10 TIMES A YEAR	(6) AT LEAST MONTHLY	(7) AT LEAST WEEKLY	(8) ALMOST DAILY
a. SLEEP							
b. QUIET ACTIVITY							
c. SOCIALIZATION WITH FRIENDS							
d. SCHOOL OR WORK ATTENDANCE							
e. OUTDOOR ACTIVITIES							
f. VIGOROUS/PLAY ACTIVITIES							

6. SEVERITY LEVEL. What is the family member's severity level based on the clinical picture? *(Select one level of severity. Definitions are examples of severity. Pulmonary function tests are required only if clinically indicated.)*

	a. INTERMITTENT ASTHMA. Intermittent symptoms $\leq$ 1 time per week. Brief exacerbations (from a few hours to a few days). Nighttime asthma symptoms < 2 times a month. Asymptomatic and normal lung function between exacerbations. PEF or FEV1 $\geq$ 80% predicted; variability < 20%.
	b. MILD PERSISTENT ASTHMA. Symptoms $\geq$ 2 times a week but < 1 time per day. Exacerbations may affect sleep and activity. Nighttime asthma symptoms > 2 times a month. PEF or FEV1 $\geq$ 80% predicted; variability 20 - 30%.
	c. MODERATE PERSISTENT. Symptoms daily. Exacerbations affect sleep and activity. Nighttime asthma > 1 time a week. Daily use of inhaled short-acting B2 agonist. PEF or FEV1 $\geq$ 60% and 80% predicted; variability > 30%.
	d. SEVERE PERSISTENT. Continuous symptoms. Frequent exacerbations. Frequent nighttime asthma symptoms. Physical activities limited by asthma symptoms. PEF or FEV1 $\leq$ 60% predicted; variability > 30%.

ADDENDUM A -2 - MENTAL HEALTH SUMMARY *(To be completed by provider)*

1a. PATIENT NAME	b. SPONSOR SSN	c. FAMILY MEMBER PREFIX

2a. PROVIDER NAME *(PCM or specialty provider)*	b. SIGNATURE	c. DATE *(YYYYMMDD)*
		

3.a. DIAGNOSIS(ES)	b. AGE AT DIAGNOSIS

4. MEDICATION HISTORY

a. MEDICATION	b. DOSAGE	c. LENGTH OF TIME ON MEDICATION	d. RESPONSE

5. HISTORY OF MENTAL HEALTH HOSPITALIZATIONS

(1) TYPE OF STAY	(2) DATES	(3) DISCHARGE DIAGNOSES
a. HOSPITAL STAYS		
b. PARTIAL-DAY HOSPITALIZATIONS		

6. HOW COOPERATIVE IS/WAS PATIENT WITH TREATMENT? *(Parent/legal guardian cooperation, if a minor)*

7. TREATMENT NEEDS WITHIN THE NEXT YEAR *(Consider increased stressors of residing in new environment (e.g.,stressors of family relocation, isolated posts, deployments, foreign cultures, restricted travel, separation from nuclear family, cost of living.)*

	NO ASSISTANCE REQUIRED		FEWER THAN 4 CONTACTS		4 OR MORE CONTACTS		INPATIENT SERVICES

8. HISTORY

YES	NO	
		a. HISTORY OF SUICIDAL GESTURES/ATTEMPTS?
		b. HISTORY OF SUBSTANCE ABUSE/ADDICTIVE BEHAVIORS/EATING DISORDERS?
		c. HISTORY OF PROBLEMS WITH AUTHORITY FIGURES?
		d. HISTORY OF PSYCHOTIC EPISODES?
		e. HISTORY OF FAMILY ADVOCACY PROGRAM INVOLVEMENT? *(If Yes and case occurred in last 18 months, include case determination, treatment and follow-up.)*

9. OTHER COMMENTS *(Include additional information that would assist in determining necessary treatments.)*

ADDENDUM B - SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY

NOTE TO PERSONNEL COMPLETING THIS FORM:

It is important to the military and to the family that the family be assigned to a location that can meet the child's educational and medical needs. Please take care in completing the requested information. **(Attach a copy of the child's most recent active Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP) to this page.)**

1. RELEASE OF INFORMATION *(To be completed by military sponsor or sponsor's spouse or civilian employee/spouse)*

I hereby authorize the release of information on the Summary and in the attached reports to personnel of the Military Departments. This information will only be used to evaluate and document my family member's need for early intervention or special education services for the purpose of assignment/coordination of my next assignment.

a. NAME OF SPONSOR	b. SSN	c. SIGNATURE OF SPONSOR OR SPONSOR'S SPOUSE	d. DATE SIGNED *(YYYYMMDD)*

2. DEPENDENT CHILD INFORMATION *(To be completed by Military Sponsor or sponsor's spouse or civilian employee/spouse)*

a. NAME OF CHILD *(Last, First, Middle Initial)*	b. CURRENT GRADE LEVEL *(If school age)*	c. DATE OF BIRTH *(YYYYMMDD)*	d. AGE *(Years/months)*	e. SEX *(X one)*
				☐ MALE ☐ FEMALE

3. EARLY INTERVENTION PROGRAM (EIP)/SCHOOL INFORMATION *(To be completed by representative of EIP or school)*

YES	NO	
		a. IS THE CHILD CURRENTLY BEING EVALUATED FOR SPECIAL EDUCATION OR EARLY INTERVENTION SERVICES?
		b. DOES THIS CHILD RECEIVE EARLY INTERVENTION SERVICES UNDER A CURRENT INDIVIDUALIZED FAMILY SERVICES PLAN (IFSP)? IF YES, DATE OF NEXT ANNUAL REVIEW
		c. DOES THIS CHILD RECEIVE SPECIAL EDUCATION SERVICES UNDER A CURRENT INDIVIDUALIZED EDUCATION PROGRAM (IEP)? IF YES, DATE OF NEXT ANNUAL REVIEW
		d. IS THE CHILD RECEIVING SERVICES UNDER A SECTION 504 PLAN?
		e. IS THE CHILD BEING "HOME-SCHOOLED"? IF YES, SPECIFY PROGRAM, IF KNOWN.

IF YOU ANSWERED "NO" to questions 3.a. through d., DO NOT complete the remainder of this section, but complete Section 6. Sign and return to sponsor.

IF YOU ANSWERED "YES" to any of questions 3.a. through d., complete the remainder of this section. Sign and return to sponsor.

4. ELIGIBILITY CRITERIA *(Indicate the eligibility criteria under which the child is eligible for Early Intervention or Special Education.)*

a. IF THE CHILD IS FROM 3 TO 21 YEARS OF AGE:

☐	AUTISTIC	☐	COMMUNICATION IMPAIRED	☐	MENTAL RETARDATION
☐	DEAF		☐ ARTICULATION		☐ MILD/MODERATE
☐	BLIND		☐ DYSFLUENCY		☐ MODERATE/SEVERE
☐	DEAF/BLIND		☐ VOICE		☐ SEVERE/PROFOUND
☐	VISUALLY IMPAIRED		☐ LANGUAGE/PHONOLOGY	☐	SPECIFIC LEARNING DISABILITY
☐	HEARING IMPAIRED	☐	TRAUMATIC BRAIN INJURY	☐	EMOTIONALLY IMPAIRED
☐	PERVASIVE DEVELOPMENTAL DISORDER	☐	ORTHOPEDICALLY IMPAIRED	☐	BEHAVIORAL/CONDUCT DISORDER
☐	DEVELOPMENTAL DELAY				
☐	OTHER HEALTH IMPAIRED *(Specify)*				

b. IF THE CHILD IS FROM BIRTH TO 3 YEARS OLD:

☐	DEVELOPMENTAL DELAY	☐	HIGH PROBABILITY FOR DEVELOPMENTAL DELAY

5. SEVERITY OF THE DISABILITY

☐	MILD	☐	MODERATE	☐	SEVERE	☐	PROFOUND

6. PROVIDER/SCHOOL OFFICIAL INFORMATION

a. NAME OF INDIVIDUAL COMPLETING THIS SECTION *(Last Name, First Name)*	b. TITLE	c. TELEPHONE NUMBER *(Include area code)*	d. FAX NUMBER *(Include area code)*

e. NAME OF SCHOOL/EARLY INTERVENTION PROGRAM	f. ADDRESS *(Include ZIP Code)*
g. SCHOOL DISTRICT	

h. SIGNATURE	i. DATE SIGNED *(YYYYMMDD)*