

MCCS-SC BEAUFORT
CHILD CARE RESOURCE & REFERRAL PROGRAM
STATEMENT OF SPECIAL NEEDS

MCCS-SC Beaufort is committed to including children with special needs in regional Child Development Programs. Special needs may require smaller group size, a teacher or provider with special skills or training, or physical changes to a classroom or FCC home. Completing this statement will help us identify any accommodation your child may need. Please check items below that apply to your child:

- 1 Asthma
- 2 Apnea
- 3 Autism (to include PDD non-specific, Asperger's Syndrome, or any Pervasive Developmental Disorder)
- 4 Allergies - severe allergies to bee stings, severe environmental allergies or severe food allergies - severe means "life threatening reaction occurs on contact with allergen"
- 5 Chromosomal disorder such as Down Syndrome, Velo-Cardio Facial Syndrome, X-Chromosome Disorders or a mutation of any chromosome.
- 6 Seizure Disorder
- 7 Diabetes
- 8 Premature birth - born before 36 weeks gestation
- 9 Developmental Disability (mental Retardation)
- 10 Developmental Delay to include communication/speech delay, social/emotional delay, motor/physical skill delay
- 11 Attention Deficit Hyperactivity disorder with or without Hyperactivity (ADHD)
- 12 Severe Behavior disorder (SBI)
- 13 Obsessive compulsive Disorder (OCD)
- 14 Other mental health conditions such as Paranoia or Schizophrenia
- 15 Hearing loss or deafness
- 16 Vision loss, or blindness
- 17 Inability to walk, to include children using a wheel chair (children 18+ months)
- 18 Suffered severe physical trauma, due to incidents such as, auto accident, severe fall, physical abuse, etc.
- 19 Suffered severe emotional trauma, due to incidents such as, auto accident, severe fall, physical abuse, death in family, chronic illness, etc.
- 20 Digestive Disorder, Specify _____
- 21 Respiratory, disorder, specify _____
- 22 Chronic Heart condition
- 23 Disorder of the spine or skeletal system such as scoliosis
- 24 Missing limb
- 25 Blood disorder such as Hemophilia
- 26 Other condition not listed, specify _____
- 27 Member of Exceptional Family Member (EFM) Program
- 28 NONE

NOTE: If your child is HIV positive, do not indicate on this form. To safeguard your child's confidentiality, please reveal your child's HIV status only to the program director.

Child's Name: _____ DOB: _____
(Please Print)

Parent's Signature: _____ Date: _____