DEPARTMENT OF TRANSPORTATION, USCG, CG-5494 (6-88)

DATE:_____

SPONSOR'S NAME:_____ SSN#:_____

RATE:_____ DISTRICT:_____ UNIT:_____

WORK NUMBER:_____ HOME ADDRESS:_____
(INCLUDE ZIP CODE)

HOME NUMBER:_____

NAME OF CHILD/SPOUSE WITH SPECIAL NEEDS:_____

DATE OF BIRTH OF CHILD/SPOUSE:_____

TYPE OF DIAGNOSED SPECIAL NEEDS CONDITION (Deaf, Vision or Speech Impaired; Cerebral Palsy; Mental Retardation; Attention Deficit Disorder; Down Syndrome; Spina Bifida; Seizure Disorder; Learning Disabilities; Developmental Delays; Emotionally Disturbed; Hydrocephalus; Chronic illnesses such as heart, kidney, cancer, asthma, blood disorders, tumors; Depression; Head or Spinal Cord Injuries; etc.):

CAUSE OF SPECIAL NEED (if known):

TYPES OF THERAPY/TREATMENT NEEDED OR CURRENTLY RECEIVING (Speech; Physical Therapy; Occupational Therapy; Psychotherapy; Chemotherapy; Radiation; Specific Medications; Medical Specialists; etc.):

SPECIAL SCHOOLS AND/OR PROGRAMS ATTENDED OR PRESENTLY ATTENDING
(Infant Stimulation; Center Base School; Home Resources; Residential Treatment Facility; Learning Disabled Classes; Resource Room; Special Education Classes; Chemical Substance
Program; etc.):

SPECIAL EQUIPMENT NEEDED (Wheelchair; neck, arm, leg and/or back braces; crutches; apnea monitor; hearing aids; glasses; modified car or van; feeding devices; communication board (Bliss); etc.):

SUPPORT GROUPS USED, IF ANY (Parents of Down Syndrome Children; Parent Groups Within Schools; Parents of Learning Disabled Children; National Parent Network on Disabilities; Easter Seals; National Cancer Society; Candlelighters; etc):

SPECIAL PROBLEMS AND/OR CONCERNS: (Availability of Special Schools and/or Programs; Lack of Medical Specialists/Therapists, Medications and Equipment; Support Groups; etc.):

NAME OF FAMILY PROGRAM ADMINISTRATOR (FPA) AND TELEPHONE NUMBER:

NAME OF UNIT FAMILY ADVOCACY REPRESENTATIVE (FAR) AND TELEPHONE NUMBER:

HAS A COPY OF THIS ENROLLMENT FORM AND SUPPORTIVE DOCUMENTATION BEEN SENT TO YOUR FPA OR DRC?

YES_____ DATE_____ NO_____

HAS A COPY OF THIS ENROLLMENT FORM AND SUPPORTIVE DOCUMENTATION BEEN SENT TO HEADQUARTERS (G-PWL-2)?

YES_____ DATE_____ NO_____

ESTIMATED DATE/YEAR OF REASSIGNMENT:_____