SCREENING OF FAMILY MEMBERS IN REMOTE OCONUS AREAS

For use of this form, see AR 608-75; the proponent agency is OACISM.

PRIVACY ACT STATEMENT

AUTHORITY:	Title 10, USC Section 3013.
PRINCIPAL PURPOSE:	Personnel Support.
ROUTINE USES:	To determine the need to complete DD Form 2792 (Exceptional Family Member Medical Summary) and DD Form 2792-1 (Exceptional Family Member Special Education/Early Intervention Summary).
DISCLOSURE:	The requested information is mandatory. Failure to respond may preclude successful processing of an application for family member travel/command sponsorship and may lead to appropriate administrative or disciplinary action against the Soldier.

If ***Yes*** is checked for any of the boxes below, the authorized local screener/medical provider must complete the applicable DD Form 2792 (medical) or DD Form 2792-1 (educational). Attach this page to DA Form 5888 (Family Member Deployment Screening Sheet).

Part A - Medical Condition - Use DD Form 2792, if applicable.

Yes	No	
☐	☐	1. Potentially life-threatening conditions and/or chronic medical/physical conditions (such as high risk newborns, patients with a diagnosis of cancer within the last 5 years, sickle cell disease, insulin-dependent diabetes) requiring follow-up support more than once a year, or specialty care.
☐	☐	2. Current and chronic (duration of 6 months or longer) mental health condition (such as bi-polar, conduct, major affective, or thought/personality disorders); inpatient or intensive outpatient mental health service within the last 5 years; intensive (greater than one visit monthly for more than six months) mental health services required at the present time. This includes medical care from any provider, including a primary health care provider.
☐	☐	3. A diagnosis of asthma or other respiratory-related diagnosis with chronic recurring wheezing which meets one of the following criteria: - Scheduled use of inhaled anti-inflammatory agents and/or bronchodilators. - History of emergency room use or clinic visits for acute asthma exacerbations within the last year. - History of one or more hospitalizations for asthma within the past 5 years. - History of intensive care unit admissions for asthma within the past 5 years.
☐	☐	4. A diagnosis of attention deficit disorder/attention deficit hyperactivity disorder that meets one of the following criteria: - A co-morbid psychological diagnosis. - Requires multiple medications, psycho-pharmaceuticals (other than stimulants), or does not respond to normal doses of medication. - Requires management and treatment by mental health provider (e.g., Psychiatrist, Psychologist, or Social Worker). - Requires specialty consultant, other than a family practice physician or general medical officer, more than twice a year on a chronic basis. - Requires modifications of the educational curriculum or the use of behavioral management staff.
☐	☐	5. Requires adaptive equipment (such as an apnea home monitor, home nebulizer, wheelchair, splints, braces, orthotics, hearing aids, home oxygen therapy, home ventilator, etc.).
☐	☐	6. Requires assistive technology devices (such as communication devices) or services.
☐	☐	7. Requires environmental/architectural considerations (such as limited numbers of steps, wheelchair accessibility/housing modifications and air conditioning).

It is DoD policy that family members of active duty service members and civilian employees appointed to an overseas position who are eligible for early intervention or special education or meet one or more of the following criteria shall be identified as a family member with special educational needs.

Part B - Educational Condition - Use DD Form 2792-1, if applicable.

Yes	No	
☐	☐	1. Has or requires an Individualized Education Program (IEP) - for preschool and school-aged children.
☐	☐	2. Has or requires an Individualized Family Service Plan (IFSP) - for children birth to 36 months.

☐ I did not ☐ I did identify a family member with a medical or educational condition that meets the above criteria (identify family member's status in Part B of DA Form 5888).

Print Sponsor's Name	Signature of Local Screener/Medical Provider	Date (YYYYMMDD)