MEDICAL AND EDUCATIONAL INFORMATION
FAMILY MEMBER TRAVEL SCREENING WORKSHEET

SPONSOR INFORMATION

Name:
(Last, First, Middle Initial)
Rank/Grade:
DoD ID Number/SSN: **Email:**
Primary Phone Number: **Alternate Phone:**

Current assignment location:
Projected assignment location:

FAMILY MEMBER TO BE SCREENED

Name:
(Last, First, Middle Initial)
Relationship: **Birthdate:**
(Spouse, child, etc.) *(MM/DD/YY)*

RELEASE OF INFORMATION NOTIFICATION:

As part of the EFMP process, I hereby authorize the EFMP staff and the Medical Review Officers (MRO) full and complete access to my medical, mental health and/or educational records in whatever form they may exist, including but not limited to documents, electronic databases such as AHLTA, HAIMS, JLV, Tricare, or other databases, and/or correspondence from any and all military, private, Veterans Administration, or public health source(s) physicians, health care providers, and educational services providers as well as from all outpatient and in-patient treatment and rehabilitation facilities.

As part of the EFMP process, in order to have a fair, complete, and accurate evaluation of your medical, dental, and educational needs, the consent to release all medical, dental, and education information is needed to determine whether travel with your family from your current assignment to your projected assignment can be recommended. Failure to release this information, providing false or misleading information, knowingly and/or intentionally omitting information, or delaying or preventing the gathering of information may result in ineligibility or a non-travel recommendation for accompanied family travel at government expense; however, refusal to sign does not preclude the provision of medical and dental information authorized by other regulations.

PATIENT NAME	RELATIONSHIP (I.e. self, parent, etc.)	SIGNATURE	DATE (MM/DD/YY)

(SEE NEXT PAGE)

FAMILY MEMBER NAME (Last, First, Middle Initial)	SPONSOR NAME	SPONSOR SSN (LAST 4)

1. Enrolled in EFMP?.....**YES** ☐ **NO** ☐

2. In the last five (5) years, have you been referred to Family Advocacy?.....**YES** ☐ **NO** ☐

3. ANTICIPATED MEDICAL NEEDS

Does this family member currently have:	**Yes***	**No**	**N/A**
Any cardiovascular conditions, e.g., chest pain/angina, arrhythmia, valve disease, infarction, etc., requiring ongoing care?	☐	☐	☐
Any neurologic conditions, e.g., seizure, migraine, neuropathy, etc., requiring ongoing care?	☐	☐	☐
Any respiratory conditions, e.g., asthma, Reactive Airway Disease (RAD), allergies requiring immunotherapy, etc.?	☐	☐	☐
Had an environmental asthma trigger that could limit relocation to specific geographic areas?	☐	☐	☐
A temporary condition, e.g., injury, recent illness, etc.?	☐	☐	☐
A condition that may require surgery in the next twelve (12) months?	☐	☐	☐
In primary or secondary school (grade Kinder through High School) and receiving psychological or counseling services not included on an IEP?	☐	☐	☐
Declining any vaccinations?	☐	☐	☐
Outstanding specialist referrals?	☐	☐	☐
Pregnancy?	☐	☐	☐

*For any "yes" answers, please provide additional details below or make sure to include on the "current medical conditions" page.

In the last year (12 months) has this family member required:	**Yes***	**No**	**N/A**
Any examinations with abnormal results, e.g., prostate, mammogram, pap smear, etc.?	☐	☐	☐
Oral steroids for more than seven (7) days in the past year to treat asthma or reactive airway disease?	☐	☐	☐
A visit to the emergency room?	☐	☐	☐
Hospitalization (excluding childbirth)?	☐	☐	☐
Medical services from any specialists (not general pediatrics, family practice, and general internal medicine)?	☐	☐	☐
Specialized equipment, e.g., a wheelchair, walker, apnea monitor, insulin pump, etc.?	☐	☐	☐
Special environmental considerations, e.g., limited steps, temperature control, air filtering, etc.?	☐	☐	☐
Speech, physical, or occupational therapy, or Applied Behavior Analysis (ABA) through TRICARE or private health insurance?	☐	☐	☐

*For any "yes" answers, please provide additional details below or make sure to include on the "current medical conditions" page.

(SEE NEXT PAGE)

FAMILY MEMBER NAME (Last, First, Middle Initial)	SPONSOR NAME	SPONSOR SSN (LAST 4)

In the last five (5) years has this family member had:	**Yes**	**No**	**N/A**
A vision impairment not corrected by glasses?			
A hearing impairment?			
A diagnosis or treatment (to include medication) from any provider for a behavioral health problem, e.g., depression, eating disorders, self-harming behaviors, acting out behaviors, etc.?			
A referral or treatment in any of the following: inpatient psychiatric facility, residential treatment program, group home, day treatment center, or drug or alcohol treatment rehabilitation center?			
A referral or treatment for suicidal thoughts, gestures, or attempts?			
A referral or treatment alcohol/drug use or abuse?			
A condition that requires follow-up care from a primary care manager (to include pediatricians) more than once a year or specialty care. For example, cancer, diabetes, TBI, seizure disorders, cerebral palsy, sickle cell, chronic pain, etc.?			

*For any "yes" answers, please provide additional details below or make sure to include on the "current medical conditions" page.

4. SPECIAL EDUCATIONAL NEEDS/EARLY INTERVENTION (IF AGE 21 OR YOUNGER)

Is this family member:	Yes	No	N/A
Currently receiving early intervention services?			
Currently receiving special education services to include physical, occupational, or speech therapy services from the school system?			
Currently being evaluated to determine eligibility for early intervention or special education services?			
Homeschooled or attending a private/charter school?			
Withdrawn from early intervention or special education services within the last twelve (12) months?			
Ever receive special education services?			
Ever receive physical, occupational, or speech therapy services?			

(SEE NEXT PAGE)

FAMILY MEMBER NAME (Last, First, Middle Initial)	SPONSOR NAME	SPONSOR SSN (LAST 4)

5. CURRENT MEDICAL CONDITIONS

DIAGNOSIS #1: _____

Date of original diagnosis:

Medications:

Name of Medicine	*How taken (by mouth, injection, etc.)*	*How often (daily, every 8 hours, etc.)*

(Attach additional document/list, if necessary)

Frequency of appointments:

Primary provider/clinic that manages this diagnosis:

Concerns about travel:

DIAGNOSIS #2: _____

Date of original diagnosis:

Medications:

Name of Medicine	*How taken (by mouth, injection, etc.)*	*How often (daily, every 8 hours, etc.)*

(Attach additional document, if necessary)

Frequency of appointments:

Primary provider/clinic that manages this diagnosis:

Concerns about travel:

(SEE NEXT PAGE)

FAMILY MEMBER NAME (Last, First, Middle Initial)	SPONSOR NAME	SPONSOR SSN (LAST 4)

DIAGNOSIS #3: _____

Date of original diagnosis:

Medications:

Name of Medicine	*How taken (by mouth, injection, etc.)*	*How often (daily, every 8 hours, etc.)*

(Attach additional document, if necessary)

Frequency of appointments:

Primary provider/clinic that manages this diagnosis:

Concerns about travel:

DIAGNOSIS #4: _____

Date of original diagnosis:

Medications:

Name of Medicine	*How taken (by mouth, injection, etc.)*	*How often (daily, every 8 hours, etc.)*

(Attach additional document, if necessary)

Frequency of appointments:

Primary provider/clinic that manages this diagnosis:

Concerns about travel:

(END OF WORKSHEET)