

SNAP #

SPECIAL NEEDS ALERT PROGRAM ENROLLMENT FORM

Child's Name:		Name Child Responds To:	
Date of Birth:			
Parent(s)/Guardian(s):			
Home Phone:		Work Phone:	
Cell Phone:		Email:	
HOME INFORMATION			
Street Address:			
City:		Zip:	County:
Home Description:			
Best Entrance for EMS Responders:			
Child's room location:			
Local Fire Department/Ambulance Service:			
Caregiver's Name (if other than parent/guardian):			
Caregiver's Phone:			
CHILD CARE/SCHOOL/DAY PROGRAM INFORMATION			
Child Care/School/Day Program:			
Street Address:			
City:		Zip:	County:
Local Fire Department/Ambulance Service:			
MEDICAL INFORMATION			
Primary Medical Issue:			
Other Medical Issues/Diagnoses:			
Technology/Assisted devices:			
Special Instructions:			

FOR INTERNAL USE ONLY

Date of Application:	<input type="checkbox"/> Technology	<input type="checkbox"/> Behavioral
Date of Enrollment:	<input type="checkbox"/> Non-Technology	<input type="checkbox"/> Medication
Date of Home Visit:	Agency:	



DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

