



DISABILITY ASSISTANCE GRANT
Children (Under 18 Years)
MEDICAL REPORT
1: Beneficiary Information

Full Name: _____
Last First Middle

Also Known As: _____

Date of Birth _____ Age: _____ Gender: _____

Address: _____
Street Address (where child lives)

Town / City _____ Country _____

2.1: Existing Diagnosis (Attach Copies of relevant documents)

Diagnosis: _____

Description of how condition affects the child's/family's daily life and activities

Recommendations

2.2: Medical Diagnosis Resulting in Disability

Is the condition permanent? Yes: ☐ No: ☐ If no, please state the duration: _____

Diagnosis: _____

Description of how condition affects the child's/family's daily life and activities

Recommendations

2.3: Physical Disability

(i) Visual: None ☐ Mild ☐ Moderate ☐ Severe ☐ Complete ☐ Not Specified ☐ Not Applicable ☐

Is the condition permanent? Yes ☐ No: ☐ If no, please state the duration: _____

Diagnosis: _____

Description of how condition affects the child's/family's daily life and activities

Recommendations

(ii) Hearing: None ☐ Mild ☐ Moderate ☐ Severe ☐ Complete ☐ Not Specified ☐ Not Applicable ☐

Is the condition permanent? Yes ☐ No: ☐ If no, please state the duration: _____

Diagnosis: _____

Description of how condition affects the child's/family's daily life and activities

Recommendations

(iii) Motor Functions : None ☐ Mild ☐ Moderate ☐ Severe ☐ Complete ☐ Not Specified ☐ Not Applicable ☐

Is the condition permanent? Yes ☐ No: ☐ If no, please state the duration: _____

Diagnosis: _____

Description of how condition affects the child's/family's daily life and activities

Recommendations

2.4: Developmental Disability

Communications Skills							
Expression	None ☐	Mild ☐	Moderate ☐	Severe ☐	Complete ☐	Not Specified ☐	Not Applicable ☐
Reception	None ☐	Mild ☐	Moderate ☐	Severe ☐	Complete ☐	Not Specified ☐	Not Applicable ☐
Self-Care	None ☐	Mild ☐	Moderate ☐	Severe ☐	Complete ☐	Not Specified ☐	Not Applicable ☐
Social / Emotional	None ☐	Mild ☐	Moderate ☐	Severe ☐	Complete ☐	Not Specified ☐	Not Applicable ☐
Cognitive / Intellectual	None ☐	Mild ☐	Moderate ☐	Severe ☐	Complete ☐	Not Specified ☐	Not Applicable ☐

Is the condition permanent? Yes ☐ No ☐ If no, please state the duration: _____

Diagnosis: _____

Description of how condition affects the child's/family's daily life and activities

Recommendations

Special Education: Yes ☐ Full Time ☐ Part Time: ☐ No ☐

Teachers Aid: Yes ☐ No ☐

Speech Therapy: Yes ☐ No ☐ Language Therapy: Yes ☐ No ☐ Personal Care Assistance: Yes ☐ No ☐

Other ☐ Please specify: _____

2.5: Mental Health

None ☐ Mild ☐ Moderate ☐ Severe ☐ Complete ☐ Not Specified ☐ Not Applicable ☐

Is the condition permanent? Yes ☐ No ☐ If no, please state the duration: _____

Diagnosis: _____

Description of how condition affects the child's/family's daily life and activities

Recommendations

2.6: Other Information

Provide any other information which is relevant to determine the extent of the child's disability:

2.7: Overall Assessment

Impact of disability on the child's level of functioning

None ☐ Mild ☐ Moderate ☐ Severe ☐ Complete ☐ Not Specified ☐ Not Applicable ☐

Is the condition permanent? Yes ☐ No ☐ If no, please state the duration: _____

Status to be reviewed in: _____ Medical Board Number: _____

Medical Officer: _____

BLOCK LETTERS

Medical Officer Signature