Government of the Republic of Trinidad and Tobago
Ministry of the People, Social Development and Family Services

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