



# Parent Central Services Registration Checklist

## Moore Child Development Center



Phone: 717.245.3701

455 Fletcher Rd.

Children/Youth must be fully registered before they can use any CYS Services Program.

To expedite the registration process, please have the following information available.

ITEMS/INFORMATION TO BRING TO REGISTRATION APPOINTMENT	VERIFICATION
<b>ID Card</b> (Military or DOD)	
<b>Proof of Child Eligibility</b> (Birth Certificate)	
<b>Child's Official Shot Record</b> (fifth grade and below, Homeschool, and Private School)	
<b>Family Care Plans DA5305</b> (Required for single/dual military and single/dual deployable civilian families) (Due 30 days from enrollment in part/full time programs)	
<b>Proof of Parent(s) Income</b> (i.e. Leave and Earnings Statement/Pay Vouchers. If spouse is a full time student, proof of enrollment is needed. Determination of DOD Fee Category for child care/school age fees is based on Total Family Income) 3 consecutive paystubs needed, unless ACTIVE DUTY	
<b>Program Information Form</b> Local Emergency and Child Release Designees (minimum of 2) (names/phone numbers - if you are unable to be reached in case of emergency, designees will be called and must live within 30 minutes of Carlisle Barracks) *Must be two people other than sponsor & spouse	
<b>Program Agreement</b>	
<b>Child and Family Profile</b>	
<b>Current Health Insurance Form</b>	
<b>Child Health Assessment/Sports Physical Form</b> (due within 30 days of your registration appointment for children birth through 5 <sup>th</sup> grade) (Sports physical portion is valid for one year and due before participation in any sports activities for all ages. Sports Physical must be valid through sport season)	
<b>Health Screening Tool-1</b> (To record/evaluate child's allergies, medical/physical conditions, etc. for all children birth through 5 <sup>th</sup> grades and ALL Youth identified as having special needs)	
<b>Medical Action Plan (MAP)</b> Only needed if a child is <b>diagnosed</b> with allergies, diabetes, asthma/respiratory or seizures that requires staff to give rescue medications) (If recommended by Special Needs Assessment Team) (New Medical Action Plans are required yearly at re-registration)	
<b>Child/Adult Care Food Program Child Enrollment Form</b>	
<b>Child Care Center Meal Benefit Income Eligibility Form</b>	
<b>Liability Waiver Form</b>	

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Registration completed by: \_\_\_\_\_ Date: \_\_\_\_\_

# Army Child, Youth and School Services (CYSS)

## Program Information Form

### DATA REQUIRED BY THE PRIVACY ACT OF 1974

**AUTHORITY:** Title 10, United States Code, Section 3012. **PRINCIPAL PURPOSE(S):** To provide child and family program eligibility, background information and sponsor consent for access to emergency medical care. **ROUTINE USES:** Information is furnished to the attending physician when it is necessary for an individual to be taken to a medical facility by someone other than the parent. **DISCLOSURE:** Disclosure of requested information is voluntary, however, if information is not provided, individual(s) may not be allowed to participate in the CYS Program.

**DECLARATION OF NONDISCRIMINATION:** Services will be made available to all youth in attendance, without regard to race, religion, national origin, ancestry, or sex, within the limits of AR 608-10.

Sponsor's Name: \_\_\_\_\_ Grade/ Rank: \_\_\_\_\_

Status: Active Duty    Guard    Reserve    DoD Civilian    Eligible Contractor    IF Student

Branch of Service: Army    Air Force    Navy    Marine Corps    Coast Guard

Installation Assigned (i.e. Carlisle Barracks, Letterkenny): \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Live On-Post?    Yes    No

Sponsor's Email Address (AKO Preferred): \_\_\_\_\_

Spouse/Other Adult Contributor Name: \_\_\_\_\_ Grade/Rank: \_\_\_\_\_

Status: Active Duty    Guard    Reserve    DoD Civilian    Eligible Contractor    Stay at Home Parent

Branch of Service: Army    Air Force    Navy    Marine Corps    Coast Guard

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Spouse's/Alternate Email \_\_\_\_\_

Child's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ School: \_\_\_\_\_

### Emergency Contacts

(We need three local contacts, other than sponsor or spouse, authorized to respond in an emergency)

Name: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Can your child/children be picked up by this person?    Yes    or    No

Name: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Can your child/children be picked up by this person?    Yes    or    No

Name: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Can your child/children be picked up by this person?    Yes    or    No

## CHILD DEVELOPMENT SERVICE (CDS) SPONSOR/PROGRAM AGREEMENT

For use of this form, see AR 608-10; the proponent agency is DCS, G-1.

### DATA REQUIRED BY THE PRIVACY ACT OF 1974

**AUTHORITY:** Title 10, United States Code, Section 3013

**PRINCIPAL PURPOSE:** Information is used by DA personnel and patrons to: (1) Identify and clarify responsibilities of all parties involved in agreement, (2) specify commitment regarding acceptance and provision of CDS services.

**ROUTINE USES:** Information provided may be released IAW the Army's blanket routine uses contained in AR 340-21.

**DISCLOSURE:** Disclosure of requested information is voluntary; however, if information is not provided, individuals may not be able to participate in CDS programs.

NAME OF SPONSOR (Last, first, MI)

PROGRAM **Carlisle, CDC** VALID FROM (Month, day, year to month, day, year)

SERVICE (Check appropriate box)

☐ FULL DAY ☐ PART DAY PRESCHOOL ☐ PART DAY SCHOOL AGE ☐ FCC HOME ☐ HOURLY

AGE GROUP CATEGORY (Check appropriate box)

☐ INFANT ☐ TODDLER ☐ PRESCHOOL AGE ☐ SCHOOL AGE

I agree to enroll my child/children

in the **Moore Child Development Center**

CDS Facility/Family Child Care Home located at

**455 Fletcher Road**

### PROGRAM SERVICES

PROGRAM OPERATING HOURS ARE AS FOLLOWS (List hours) (CDS personnel)

MON 0630 TO 1730 TUES 0630 TO 1730 WED 0630 TO 1730

THURS 0630 TO 1730 FRI 0630 TO 1730 SAT \_\_\_\_\_ TO \_\_\_\_\_

SUN \_\_\_\_\_ TO \_\_\_\_\_

\*SERVICES FOR MY CHILD/CHILDREN WILL BE AS FOLLOWS (List hours) (Sponsor)

MON \_\_\_\_\_ TO \_\_\_\_\_ TUES \_\_\_\_\_ TO \_\_\_\_\_ WED \_\_\_\_\_ TO \_\_\_\_\_

THURS \_\_\_\_\_ TO \_\_\_\_\_ FRI \_\_\_\_\_ TO \_\_\_\_\_ SAT \_\_\_\_\_ TO \_\_\_\_\_

SUN \_\_\_\_\_ TO \_\_\_\_\_

SERVICES WILL NOT BE AVAILABLE ON (List time/date) (CDS personnel)

\*Authorized Closure (no fee adjustment) \_\_\_\_\_ I WILL BE NOTIFIED IN ADVANCE, WHENEVER POSSIBLE,  
OF ADDITIONAL PERIODS OF NON-SERVICE AS DETERMINED BY CDS PERSONNEL.  
( CHILD MAY BE DENIED CARE WHEN ILLNESS PRECLUDES PARTICIPATION IN ROUTINE PROGRAM ACTIVITIES )

PRIOR NOTICE REQUIREMENT (List amount of time required to terminate services) (CDS Personnel)

Failure to provide two weeks advance notice for cancellation will result in the weekly fee charge to the household.

### UNIQUE CONSIDERATIONS (Sponsor)

I REQUEST THE FOLLOWING SPECIAL NEEDS OF MY CHILD/CHILDREN AS ACCOMMODATED

MY CHILD/CHILDREN REQUIRES THE FOLLOWING SPECIAL ITEMS WHICH I WILL SUPPLY

\*NON APPLICABLE FOR HOURLY SERVICES

**FEES AND CHARGES (CDS Personnel)**

RATES FOR PROGRAM SERVICES ARE AS FOLLOWS:

Fee Category: \_\_\_\_\_ Bi-Monthly Tuition: \_\_\_\_\_ or Monthly Tuition: \_\_\_\_\_

Part Day Tuition: \_\_\_\_\_ Hourly: \$5.00 hour up to 15 hours a week on space available basis.

I understand that I am choosing not to provide my Pay/LES and I understand I will be placed in CAT 9. \_\_\_\_\_

MISCELLANEOUS FEES FOR PROGRAM SERVICES ARE AS FOLLOWS:

Late fee payments are \$10.00 per child for monthly (Full day) and a one time late fee of \$20.00 for monthly (Part Day).

These fees will be assessed on the 6th business day. Late Pick-up Fees are \$1.00 per minute for the first 15 minutes, then

\$5.00 for the next 45 minutes. Late pick up fees are assessed per site. Return Check Fee is \$25.00

AN OVERTIME/LATE FEE OF \$ 1.00 per minute WILL BE CHARGED STARTING AT 1730 HOURS.

\*PAYMENT OBLIGATION IS BASED ON HOURS I AGREE TO USE SERVICES NOT ON ACTUAL HOURS OF CHILD ATTENDANCE, UNLESS THEY EXCEED THE HOURS CONTRACTED.

\*IN THE EVENT OF ABSENCE OF MY CHILD/CHILDREN FROM CARE DUE TO ILLNESS, FEES WILL WILL NOT BE REDUCED.

\*IN THE EVENT OF ABSENCE OF MY CHILD/CHILDREN FROM CARE DUE TO VACATION, FEES WILL WILL NOT BE REDUCED.

FEES WILL BE PAID IN THE FOLLOWING MANNER

Hourly Care fees will be paid daily upon pick up.

Part Day Preschool/Pre-Kindergarten fees will be paid monthly in advance.

Full Day fees will be paid bi-monthly or monthly in advance.

Note: Full Day fees include 10 days of Non-Paid Child Care Leave

FEES AND CHARGES ARE SUBJECT TO CHANGE. PATRONS WILL BE NOTIFIED OF CHANGES 30 DAYS PRIOR TO EFFECTIVE DATE.

**POLICIES (CDS Personnel)**

\*CHILD MEDICATION WILL BE ADMINISTERED ONLY UPON MY WRITTEN REQUEST UNDER THE FOLLOWING CDS CONDITIONS

Medication Administration is authorized in Full Day Care only. Medication must be prescribed. Physician or parents must administer first dose. Children will be on oral medication for 24 hours before dosage is administered by CDS Personnel. DA Form 5225-R (CDS Medical Dispensation Record) must be completed prior to administration of medication. Only physician prescribed medications are permitted within CDC programs.

LAUNDERING CHILD'S/CHILDREN'S SOILED CLOTHING WILL/WILL NOT BE DONE ON A ROUTINE BASIS.

I WILL PROVIDE THE FOLLOWING TO MEET CDS PROGRAM REQUIREMENTS

CDS Requirements:

- Provide daily telephone numbers for emergency notification.
- Provide Health Assessment within 30 days of registration (if no specials needs)
- Provide Family Care Plan within 30 days of registration (single/dual military)
- Provide Notifications of Immunizations (if applicable)

I ACKNOWLEDGE A SHARED RESPONSIBILITY WITH CDS FOR CHILD ABUSE PREVENTION

Child abuse prevention is a shared responsibility of parents and CDS staff. We will work cooperatively to keep each other informed on a daily basis and maintain open communication on behalf of the child's health and welfare. CDS has an open door policy and welcomes visits by parents. IAW AR608-10, Para 2-20 and and AR 608-18, all CDS employees are mandated to report ALL suspected child abuse.

I ACKNOWLEDGE AND CONSENT TO THE FOLLOWING CDS POLICIES CONCERNING THE CARE OF MY CHILD

A parent handbook is provided. Parents must ensure the understanding and compliance with policies and procedures. As changes occur, you will be given updated statements. Parents will be notified daily of any unusual occurrences concerning their children.

Children are accepted on a trial basis not to exceed 30 days from the first date of attendance. If at any time during that period, it is determined by CDS that the child's needs cannot be accommodated in the CDS delivery systems, the Outreach Services Director will assist in referral.

\*All CDS program closures correspond with the direction and guidance from the Garrison Commander's Office. For 24 hour status updates on closures, please call 717-245-3700. Fee adjustments will NOT be made due to holidays, closures, or delays.

SIGNATURE OF SPONSOR

DATE

SIGNATURE OF CDS REPRESENTATIVE OR FCC PROVIDER

DATE

**CHILD DEVELOPMENT SERVICES (CDS) CHILD AND FAMILY PROFILE**

For use of this form, see AR 608-10; the proponent agency is DCSPER

**DATA REQUIRED BY THE PRIVACY ACT OF 1974**

**AUTHORITY:** Title 10, United States Code, Section 3013

**PRINCIPAL PURPOSE:** Information is used by DA personnel to: (1) develop programs meeting needs of child and family, (2) ensure appropriate placement of child, (3) identify contingency plan for child illness, (4) verify Family Care Plan, and (5) identification of potential program volunteers.

**ROUTINE USES:** Information provided may be released IAW the Army's blanket routine uses contained in AR 340-21.

**DISCLOSURE:** Disclosure of requested information is voluntary; however, if information is not provided, individuals may not be able to participate in CDS programs.

NAME OF SPONSOR (Last, first, MI)	DATE
ADDRESS (Include ZIP Code)	TELEPHONE
DUTY ADDRESS (Include ZIP Code)	TELEPHONE

**CHILD DATA**

NAME (Last, first, MI)	NICKNAME	BIRTH DATE
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**DEVELOPMENTAL TASKS/ACCOMPLISHMENTS FOR INFANTS AND TODDLERS (Check appropriate blocks)**

SITS	<input type="checkbox"/> WITH SUPPORT	<input type="checkbox"/> INDEPENDENTLY
WALKS	<input type="checkbox"/> WITH SUPPORT	<input type="checkbox"/> INDEPENDENTLY
SPEECH	<input type="checkbox"/> SINGLE WORDS	<input type="checkbox"/> PHRASES <input type="checkbox"/> SENTENCES
TOILET TRAINED	<input type="checkbox"/> DAY	<input type="checkbox"/> NIGHT
SELF-HELP SKILLS	<input type="checkbox"/> FEEDS	<input type="checkbox"/> TOILETS <input type="checkbox"/> DRESSES
READINESS SKILLS	<input type="checkbox"/> TIES	<input type="checkbox"/> ZIPS <input type="checkbox"/> BUTTONS/SNAPS
ATTENTION SPAN	<input type="checkbox"/> COLORS	<input type="checkbox"/> PRINTS NAME <input type="checkbox"/> CUTS
ACTIVITY LEVEL	<input type="checkbox"/> SPORADIC	<input type="checkbox"/> MODERATE <input type="checkbox"/> SUSTAINED
PLAYS	<input type="checkbox"/> LOW	<input type="checkbox"/> MODERATE <input type="checkbox"/> HIGH
	<input type="checkbox"/> ALONE	<input type="checkbox"/> NEAR OTHERS <input type="checkbox"/> WITH OTHERS

**INFANTS/TODDLER UNIQUE VOCABULARY (List child's special words and what they actually mean)**

CHILD'S WORDS	MEANING	CHILD'S WORDS	MEANING
	DRINK		
	BATHROOM		
	BOWEL MOVEMENT		
	URINATION		
	SPECIAL TOY(S)		

**CHILD'S PREFERENCES**

FOODS	TOYS	PASTIMES

**SPECIAL CONSIDERATIONS**

FEARS/DISLIKES	PERSONALITY CHARACTERISTICS	SPECIAL NEEDS

PREVIOUS GROUP EXPERIENCES	RESPONSE TO NEW/STRANGE SITUATION
NAP (Comments) <input type="checkbox"/> YES <input type="checkbox"/> NO	BEDTIME (Time, etc.)

**FAMILY DATA**

HOUSEHOLD MEMBERS			PETS	
NAME	AGE	RELATIONSHIP TO CHILD	TYPE	NAME

REASONS(s) FOR USE OF CDS PROGRAM(s)

CONTINGENCY CARE PLAN FOR CHILD ILLNESS

CAR POOL/TRANSPORTATION ARRANGEMENTS

FAMILY CARE PLAN *(Sole Parent/Dual Sponsors)*

VOLUNTEER AVAILABILITY *(Check appropriate blocks)*

☐ FIELD TRIPS AIDE

☐ HOLIDAY ACTIVITIES

☐ AT HOME PROJECTS

☐ ON SITE ADMINISTRATIVE/CURRICULUM PROJECTS

☐ TOY/EQUIPMENT REPAIR

☐ CLASSROOM AIDE

OTHER \_\_\_\_\_

EMERGENCY NOTIFICATION DESIGNEE	HOME PHONE	DUTY PHONE	CHILD RELEASE DESIGNEE
EMERGENCY NOTIFICATION DESIGNEE	HOME PHONE	DUTY PHONE	CHILD RELEASE DESIGNEE
EMERGENCY NOTIFICATION DESIGNEE	HOME PHONE	DUTY PHONE	CHILD RELEASE DESIGNEE

REMARKS

**Current Health Insurance Information**

Sponsor's Name: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

No Insurance

Parent/Sponsor does not wish to provide insurance information

Signature of Parent/Sponsor

# HEALTH ASSESSMENT/SPORTS PHYSICAL STATEMENT (HASPS) for CYS SERVICES ENROLLMENT, Renewal & SPORTS PHYSICAL Requirements

Revised 08Jan 09

## DATA REQUIRED BY THE PRIVACY ACT OF 1994

**PRINCIPAL PURPOSE:** Information is used by DA personnel to: (1) verify child health status of immunization per admission requirements; (2) note special program considerations or restriction on child participation; (3) execute emergency medical procedure for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program; (5) certify physically fit to participate in sports. **ROUTINE USES:** No information is disclosed outside DOD. **DISCLOSURE:** Information is voluntary; however, if information is not provided, individuals may not be able to participate in community activities.

**INSTRUCTIONS:** All sections A, B, C. must be completed

### PART: A Medical History (Filled out by parent / guardian)

Name of Sponsor	Home Telephone	Duty/Work Telephone
	Cell Telephone	
Sponsor Unit / Work Address	Sponsor SSN XXX-XX-XXXX	Spouse's Work Telephone

### CHILD HEALTH INFORMATION

Name of Child	Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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Does your child have ongoing medical concerns?  
(If Yes, explain circumstances and current status)

☐ Yes ☐ No

Is your child enrolled in Exceptional Family Member Program?  
(If Yes, explain)

☐ Yes ☐ No

### MEDICAL HISTORY

	YES	NO		YES	NO
1. Any hospitalization or operations			14. Heat stroke or exhaustion		
2. Allergies to medicine, insect bites or food			15. Broken bones or sprains		
3. Speech or development delays			16. Joint injuries (Ankle/Knee/Wrist)		
4. Vision Problems (Glasses / Contacts)			17. Required restricted physical activity		
5. Ear or hearing problems			18. Diabetes		
6. Seizures or Convulsions			19. Cancer		
7. Dizziness or fainting with exercise			20. Dental or orthodontic braces		
8. Headaches			21. Learning problems		
9. Head injury or loss of consciousness			22. Sleep problems		
10. Neck or back injury			23. Behavioral problems		
11. Asthma or difficulty breathing			24. ADD / ADHD		
12. Heart or blood pressure problems			25. Autism Spectrum Disorder		
13. Chest pain with exercise			26. Other (please list below)		

If you answer yes to any of the above, please explain:

#### Ongoing Medications

Name	Dosage	Frequency

#### Allergies – All Types (Foods, Medicines and Insect Bites)

Type	Reaction



<b>PART B: Physical Exam</b>				
Medical Staff Assessment (Completed by licensed independent practitioner: Doctor-Dr., Nurse Practitioner-NP, Physician's Assistant-PA)				
Age YRS                      MOS	Height _____ cm.                      ( _____ %ile)		Weight _____ kgs.                      ( _____ %ile)	
BP:                      / P:                      /	Visual Acuity Right                      /                      Left                      /                      Tested with / without glasses			
	<b>NORMAL</b>	<b>ABNORMAL</b>	<b>N / A</b>	<b>COMMENTS</b>
1. Eyes				
2. Ears, Nose & Throat				
3. Hearing				
4. Mouth & Teeth				
5. Neck (Soft tissues)				
6. Cardiovascular				
7. Chest & Lungs				
8. Abdomen				
9. Genitalia – Hernia				
10. Skin & Lymphatics				
11. Spine – Scoliosis				
12. Extremities				
13. Neurological				
14. Wears braces / plates				
Based on this HX and PX exam, the following abnormalities were found and may need treatment:				
Immunizations are current and up to date: <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>PARTICIPATION RECOMMENDATIONS</b>				
<input type="checkbox"/> All sports                      _____ Yes                      _____ No		<input type="checkbox"/> Normal physical activity to including PE		
<input type="checkbox"/> Additional comments:		<input type="checkbox"/> Restrictions:		

**Sports Physical is valid for 1 year from date indicated below**

<b>PART C</b>		
<b>Special Medical Considerations:</b> Describe any special program needs, considerations or restrictions which the child requires in order to participate in CYS programs (to include Sports).		
Child / Youth is able to participate in normal CYS programs? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date	Licensed Health Care Professional Stamp	Licensed Health Care Professional; Dr., NP or PA Signature
Initial Date	Type or print name of Parent or Guardian	Signature of Parent or Guardian

<b>HASPS Renewal (Not Part of the Sports Physical)</b>		
Year 2 Date	Health Status Changed	Signature of Parent or Guardian
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Year 3 Date	Health Status Changed	Signature of Parent or Guardian
	<input type="checkbox"/> Yes <input type="checkbox"/> No	

# ARMY CHILD AND YOUTH SERVICES HEALTH SCREENING – TOOL #1

## PRIVACY ACT STATEMENT

**AUTHORITY:** 10 U.S.C. 3013, Secretary of the Army; 29 U.S.C. 794, Nondiscrimination Under Federal Grants and Programs, DoDD 1342.17 Family Policy; AR 608-75, Exceptional Family Member Program; AR 608-10, Child Development Services; and E.O. 9397 (SSN).

**PRINCIPAL PURPOSE:** Information will be used to assist Army activities in their responsibilities in overall execution of the Army's Exceptional Family member Program (EFMP) and the Army Child and Youth Services Program.

**ROUTINE USES:** The DoD "Blanket Routine Uses" that appear at the beginning of the Army's compilation of systems of records apply to this system

**DISCLOSURE:** Disclosure of requested information is voluntary; however, if information is not provided individual may not be able to participate in Army Child and Youth Services Program.

SNAP Case Number: \_\_\_\_\_

### FOR CER COMPLETION ONLY

- ☐ Initial Registration  
Is child on waiting list? ☐ Yes ☐ No  
Date care needed? \_\_\_\_\_
- ☐ Re-registration/Child Already in Program  
☐ Change in Program

Date in from Patron:

Date out to APHN:

## Part A – General Information

Child/Youth Name		Child/Youth School Grade (example: 3 <sup>rd</sup> Grade)	Date of birth (YYYYMMDD)	Age
Type of Placement Requested: (check all that apply)				
<input type="checkbox"/> Hourly Care	<input type="checkbox"/> Full Day Care	<input type="checkbox"/> Middle School/Teen Program	<input type="checkbox"/> Summer Camp	<input type="checkbox"/> Other: (specify)
<input type="checkbox"/> Part Day Care	<input type="checkbox"/> Before/After School Care	<input type="checkbox"/> SKIES/Instructional Classes	<input type="checkbox"/> Sports	
Sponsor Name	Sponsor E-mail	Best Contact Number		
Spouse Name	Spouse E-mail			
Home Phone	Cell Phone	Sponsor Unit		
Home Address		Sponsor Duty Phone		

## Part B – Identification of Child/Youth Condition/Restrictions

Does your child have any of the following conditions/restrictions: (check no or yes and answer questions as appropriate)

<p><b>1. Allergies</b></p> <p>a. Life threatening reaction? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>b. Rescue Medication (Epi-pen, Benadryl, Inhaler) <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>c. Does child/youth need rescue inhaler? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If your child/youth has an allergy, please list: _____</p> <p>Reaction: _____</p> <p><b>2. Special Diet</b> <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>a. Is your child on a complex diet (i.e. gluten free, diabetic) <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>b. Does your child have a food intolerance/mild food allergy (i.e. rash from strawberries/milk intolerance)? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>c. Does your child have a dietary religious restriction? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><b>3. Asthma/Reactive Airway Disease/Breathing Problems?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>a. Does your child need a rescue med? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><b>4. Does your child have diabetes?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><b>5. Does your child have seizures?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><b>6. Attention Deficit Disorder (ADD/ADHD)</b></p> <p>a. Are there behavior/conduct concerns while on meds? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>b. List ADD/ADHD medications: _____</p> <p>_____</p> <p>_____</p>	<p><b>7. Behavior/ conduct concerns (oppositional defiant disorder, anxiety, depression, bipolar, other)?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><b>8. Autism Spectrum Disorders (Autism, Aspergers, Rett Syndrome, PDD-NOS)</b> <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p><b>9. Does your child have any of the following health concerns? (circle all that apply)-</b> <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Hearing impairment, vision impairment other than corrective lenses, heart, kidney, physical disability SEVERE skin condition Please specify _____</p> <p><b>10. Does your child have a speech/language and/or hearing loss that affects their ability to communicate their basic needs (hurt, bathroom, fear, thirst)?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Explain: _____</p> <p>_____</p> <p><b>11. Does your child have developmental delays other than MILD speech language/MILD hearing loss?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Explain: _____</p> <p>_____</p> <p><b>12. Are there any other conditions or concerns that you would like staff to be aware of?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Explain: _____</p> <p>_____</p>
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## Part C – Medications

List any medications that are prescribed for your child/youth other than those listed above:

Will your child require medication administration during child care/youth supervision hours? ☐ No ☐ Yes

## Part D – Early Intervention and Special Education

Does your child/youth receive special services/therapies? <input type="checkbox"/> No <input type="checkbox"/> Yes Please specify: _____	Does your child/youth have an Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP) or 504 Plan? <input type="checkbox"/> No <input type="checkbox"/> Yes
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## Part E – Exceptional Family Member Program (EFMP) Enrollment

Is your child enrolled in the EFMP? ☐ No ☐ Yes If yes, specify for what condition: \_\_\_\_\_

Printed Name and Signature of Parent/Personal Representative of Child/Youth

Date (YYYYMMDD)

**If you have answered NO to all the questions above you are now finished with this form.**  
**Please sign and date indicating that the information above is accurate and complete to the best of your knowledge.**

Child, Youth and School Services strives to provide the safest and healthiest environment for your child/youth and relies on your accurate and honest information to support this goal. Please understand that placement and/or care for your child/youth could be delayed/suspended if information is falsified or intentionally omitted on registration documentation. If there are any changes to your child/youth's health please notify CYS Services immediately.

**If you answered YES to any of the questions above, complete Part F on the next page.**

Form Updated 11 Mar 09

Child/Youth Name	Date of birth (YYYYMMDD)	Age
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**Part F – Release of Information**

I authorize \_\_\_\_\_ (name of Medical Treatment Facility or physician's practice) to release any medical information regarding my child \_\_\_\_\_ (name of child) to the \_\_\_\_\_ (name of installation) Child & Youth Services (CYS) Special Needs Accommodation Process (SNAP) personnel and their staff that is necessary to conduct SNAP review. This authorization will remain in effect for one year. I understand I may revoke this consent in writing at any time before expiration, but any action taken by the SNAP on this authorization prior to revocation is valid and will remain in effect.

I understand that information disclosed pursuant to this authorization is For Official Use Only (FOUO) and may be subject to redisclosure. I understand that information redisclosed is no longer protected by DoD 6025, 18-R; however, confidentiality of this information will remain protected by the Privacy Act of 1974, 5 U.S.C. section 552a.

The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.

\_\_\_\_\_  
Printed Name and Signature of Parent/Personal Representative of Child

\_\_\_\_\_  
Date (YYYYMMDD)

**Part G – Army Public Health Nurse (APHN) Review**

Current Medications other than those listed on page 1:

Diagnosis: \_\_\_\_\_

Background/Notes:

Medical Records Reviewed? ☐ No ☐ Yes ☐ Not Available

Training for CYS Staff/Provider Required:

Recommendation Summary:

**SNAP REQUIRED:** ☐ No SNAP required ☐ Modified ☐ Full ☐ Annual Review (No team meeting required)

Requirements Prior to Placement:

Medical Action Plan reviewed by APHN: ☐ Respiratory ☐ Allergy ☐ Seizure ☐ Diabetes ☐ Special Diet  
☐ Other \_\_\_\_\_

APHN Printed Name or Stamp

APHN Signature

Date (YYYYMMDD)

Date Received by APHN

Date Returned to CER:

Form Updated: 11 Mar 09

**Child and Adult Care Food Program  
Child Enrollment Form**

**Sponsor:** \_\_\_\_\_  
**Center:** \_\_\_\_\_

**ENROLLMENT FORM FOR CHILDREN IN CHILD CARE (SAMPLE)**

This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period. Review completed enrollment form and enter the effective date in lower right hand section.

**PARENTS:** This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

Please complete all areas to include signing and dating same.

FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST CHILD	<input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY	<input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other: _____								<input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME		Enrollment Date: _____ Withdrawal Date: _____								
BIRTH DATE										
AGE										
SECOND CHILD	<input type="checkbox"/> Same as Above <input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY	<input type="checkbox"/> Same Times as Above <input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other: _____								<input type="checkbox"/> Same Meals as Above <input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME		Enrollment Date: _____ Withdrawal Date: _____								
BIRTH DATE										
AGE										
THIRD CHILD	<input type="checkbox"/> Same as Above <input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY	<input type="checkbox"/> Same Times as Above <input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other: _____								<input type="checkbox"/> Same Meals as Above <input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME		Enrollment Date: _____ Withdrawal Date: _____								
BIRTH DATE										
AGE										
FOURTH CHILD	<input type="checkbox"/> Same as Above <input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY	<input type="checkbox"/> Same Times as Above <input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other: _____								<input type="checkbox"/> Same Meals as Above <input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME		Enrollment Date: _____ Withdrawal Date: _____								
BIRTH DATE										
AGE										
FIFTH CHILD	<input type="checkbox"/> Same as Above <input type="checkbox"/> MONDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> SATURDAY <input type="checkbox"/> SUNDAY	<input type="checkbox"/> Same Times as Above <input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours Other: _____								<input type="checkbox"/> Same Meals as Above <input type="checkbox"/> BREAKFAST <input type="checkbox"/> A.M. SNACK <input type="checkbox"/> LUNCH <input type="checkbox"/> P.M. SNACK <input type="checkbox"/> SUPPER <input type="checkbox"/> EVENING SNACK
NAME		Enrollment Date: _____ Withdrawal Date: _____								
BIRTH DATE										
AGE										

Signature

Signature of Parent or Guardian

Date

Telephone Number of Parent or Guardian

CHILD CARE REPRESENTATIVE USE ONLY:

Name of Representative/Signature

Date

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

***This portion of the form can be used to capture multi-year annual updates.***

\*\*\*\*\*

\*\*\*\*\*

**Annual Time Period Covered by Signature:** \_\_\_\_\_ to \_\_\_\_\_

**Signature Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature Center Administrator/Home Provider** \_\_\_\_\_ **Date** \_\_\_\_\_

\*\*\*\*\*

\*\*\*\*\*

**Annual Time Period Covered by Signature:** \_\_\_\_\_ to \_\_\_\_\_

**Signature Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature Center Administrator/Home Provider** \_\_\_\_\_ **Date** \_\_\_\_\_

\*\*\*\*\*

\*\*\*\*\*

**Annual Time Period Covered by Signature:** \_\_\_\_\_ to \_\_\_\_\_

**Signature Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature Center Administrator/Home Provider** \_\_\_\_\_ **Date** \_\_\_\_\_

\*\*\*\*\*

\*\*\*\*\*

**Annual Time Period Covered by Signature:** \_\_\_\_\_ to \_\_\_\_\_

**Signature Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature Center Administrator/Home Provider** \_\_\_\_\_ **Date** \_\_\_\_\_

\*\*\*\*\*

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***Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800)877-8339; or (800) 845-6136 (Spanish).***

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# Child and Adult Care Food Program Child Care Center Meal Benefit Income Eligibility Form

## Part 1. All Household Members

**Names of Enrolled Child(ren)**  
(First, Middle Initial, Last)

Check if a foster child (the legal responsibility of a welfare agency or court)  
\* If all children Listed below are foster children, skip to Part 5 to sign this form.

Check if NO income

	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

**Names of all Household Members** (First, Middle Initial, Last)

	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

**Part 2. Benefits:** If any member of your household received [State SNAP], [FDPIR], or [State TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**  
NAME: \_\_\_\_\_ CASE NUMBER: \_\_\_\_\_ - \_\_\_\_\_

**Part 3.** If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call **[Your center director, Homeless Liaison, Migrant Coordinator at Phone #]** Homeless ☐ Migrant ☐ Runaway ☐

## Part 4. Total Household Gross Income—You must tell us how much and how often

**A. Name** (List **only** household members with income)

**B. Gross income and how often it was received**

A. Name	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) Jane Smith	\$200/weekly	\$150/twice a month	\$100/monthly	\$_____/____
	\$_____/N/A	\$_____/N/A	\$_____/N/A	\$_____/N/A
	\$_____/N/A	\$_____/N/A	\$_____/N/A	\$_____/N/A
	\$_____/N/A	\$_____/N/A	\$_____/N/A	\$_____/N/A
	\$_____/N/A	\$_____/N/A	\$_____/N/A	\$_____/N/A
	\$_____/N/A	\$_____/N/A	\$_____/N/A	\$_____/N/A

## Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the back of this page.)

*I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.*

Sign Here: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Last four digits of Social Security Number: \* \* \* - \* \* - \_\_\_\_\_ ☐ I do not have a Social Security Number

**Part 6. Participant's ethnic and racial identities (optional)**

Mark one ethnic identity:

- ☐ Hispanic or Latino  
☐ Not Hispanic or Latino

Mark one or more racial identities:

- ☐ Asian  
☐ White  
☐ Black or African American  
☐ American Indian or Alaska Native  
☐ Native Hawaiian or Other Pacific Islander

**Don't fill out this part. This is for official use only.**

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: \_\_\_\_\_ Per: ☐ Week, ☐ Every 2 Weeks, ☐ Twice A Month, ☐ Month, ☐ Year Household size: \_\_\_\_\_

Categorical Eligibility: \_\_\_\_\_ Eligibility: Free \_\_\_\_\_ Reduced \_\_\_\_\_ Denied (Paid) \_\_\_\_\_ Date Withdrawn: \_\_\_\_\_

Reason for Denied: \_\_\_\_\_

Temporary: Free \_\_\_\_\_ Reduced \_\_\_\_\_ Time Period: \_\_\_\_\_ (expires after \_\_\_\_\_ days)

Determining Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Confirming Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Follow-up Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.**

Household size	Yearly
1	\$20,665
2	\$27,991
3	\$35,317
4	\$42,643
5	\$49,969
6	\$57,295
7	\$64,621
8	\$71,947
Each additional person:	+\$7,326

**Privacy Act Statement:** The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

**Non-discrimination Statement:** This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."

LIABILITY WAIVER

USAG Carlisle Barracks CYS  
459 Bouquet Rd  
Carlisle Barracks  
Carlisle PA 17013  
Phone: (717)245-4555

Sponsor's Name:  
  
Address:

Hm Ph:  
  
Wk Ph:  
  
Email:

Participant:

Guardian:

MEMORANDUM FOR RECORD  
SUBJECT: Child and Youth Services (CYSS) Statements of Understanding and Medical Consent Statement

- 1. Data Required by the Privacy Act of 1974
- 2. Authority. Title 10, United States Code, section 3012.
- 3. Principal Purpose. Information is used by DA personnel to: (1) provide Child and Family program eligibility and background information, (2) develop programs meeting needs of Children and Families, (3) ensure appropriate placement of Child, (4) identify contingency plan for Child illness, (5) identify emergency designees, and (6) collect data required by USDA food program.
- 4. Routine Uses. Information on immunization and medical problems will be used as part of the program admission screening procedure. Family income data will be used to determine USDA food program qualification and rate structures. Medical consent information is furnished to the attending physician when it is necessary for a child to be taken to a medical facility by someone other than the parent.
- 5. Disclosure. Disclosure of requested information is voluntary. However, if information is not provided, individuals may not be allowed to participate in Child and Youth Services (CYS) programs.
- 6. Statements of Understanding.
  - a. I have received the CYS Parent Handbook and will abide by all policies.
  - b. I acknowledge that CYS facilities are under video surveillance.
  - c. I have reviewed the Household and Family information file. To the best of my knowledge, the information provided to CYS is accurate and complete.
  - d. I consent to the following in reference to the care of my child: Yes No
    - i. Participation in on/off post excursions accompanied by CYSS personnel with prior knowledge. Yes No
    - ii. Transportation in a government or commercial vehicle is authorized for field trips or emergency situations. Yes No
    - iii. Use of photographs of my child for release to the Installation newspaper, civilian media, or to copyright and/or reuse in other military or civilian publications or on the Installation websites. Yes No
- 7. Medical Consent Statement.
  - a. I give consent by signing this agreement, for an authorized Child and Youth Services (CYS) representative to take my Child for care, medical or dental, in an emergency situation when the child's condition represents a serious or imminent threat to his/her life, health, or well-being.
  - b. I understand that a conscientious effort will be made to notify me before such action.
  - c. I will pay any expenses incurred.
  - d. Treatment at an Army medical facility may be provided without additional consent under provision of AR 40-3, paragraph 2-24b.

PARENT SIGNATURE

DATE