One Per Household

Army Child, Youth and School Services (CYSS)

Program Information Form

DATE:

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

5.A.01 Emergency Contacts

One Per Child
3 - 18 y.o.
valid for 1 yr.

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

CHILD HEALTH INFORMATION

Name of Child	Birth Date	Sex
		☐ Male ☐ Female

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

PART B: Physical Exam

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	

	NORMAL	ABNORMAL	N / A	COMMENTS
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: ☐ Yes ☐ No

PARTICIPATION RECOMMENDATIONS

☐ All sports _____Yes _____ No ☐ Normal physical activity to including PE

☐ Additional comments: ☐ Restrictions:

Sports Physical is valid for 1 year from date indicated below

PART C

Special Medical Considerations: 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? ☐ Yes ☐ 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**

HASPS Renewal (Not Part of the Sports Physical)

Year 2 Date **Health Status Changed** **Signature of Parent or Guardian**

☐ Yes ☐ No

Year 3 Date **Health Status Changed** **Signature of Parent or Guardian**

☐ Yes ☐ No

One Per Child - 3 y.o. to 5th Grade

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: 3rd Grade)	Date of birth (YYYYMMDD)	Age

Type of Placement Requested: (check all that apply)
☐ Hourly Care ☐ Full Day Care ☐ Middle School/Teen Program ☐ Summer Camp ☐ Other: (specify)
☐ Part Day Care ☐ Before/After School Care ☐ SKIES/Instructional Classes ☐ 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 you child have any of the following conditions/restrictions: (check no or yes and answer questions as appropriate)

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

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? ☐ No ☐ Yes
Please specify: _____

Does your child/youth have an Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP) or 504 Plan? ☐ No ☐ Yes

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

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

UNITED STATES ARMY
CHILD & YOUTH SERVICES

Child and Youth Services
Youth Program Registration & Sponsor Consent

One Per Child -
6th - 12th grade

Middle and High School Teens: It's so easy to enjoy CYS activities now! Just fill out this form (don't forget the back side), get your parent to sign it and then return it (scan, fax, email or deliver) to your local Youth Program (YP) or Parent Central Services. CYS staff will verify your registration telephonically with your parent or guardian within 5 working days of receipt of form. Here's a look at some opportunities CYS offers: dances, trips, classes, volunteer opportunities, homework assistance, up-to-date technology and internet access, place to meet friends, summer camps and more!

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, United States Code, Section 3012, DoDI 6060.02, DoDI 6060.4, AR 608-10, and AR 215-1.
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 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.

Please complete the below information. Parent will be contacted within five (5) days by a CYS staff member to verify information.

YOUTH: Last Name_____ First Name _____ Gender _____

Grade _____ School _____ DOB_____ Age _____

SPONSOR: Last Name _____ First Name _____ Rank _____

Status _____ Specify if Other _____ Branch _____

Unit/Employer _____ Unit/Employer Address _____ _____ Zip Code _____

Installation _____ Work Phone _____ Cell Phone _____

Home Phone _____ Mailing Address _____ _____ Zip Code _____

On Post?_____ Sponsor Primary Email Address _____ Alternate _____

SPOUSE: Last Name _____ First Name_____ Rank_____

Status_____ Specify if Other _____ Branch _____

Unit/Employer _____ Unit/Employer Address _____ _____ Zip Code _____

Work Phone _____ Cell Phone _____ Home Phone _____

Spouse Primary Email Address _____ Alternate _____

EMERGENCY/RELEASE CONTACTS (Local adults, not parents, authorized to respond in an emergency or locate parent):

1. Last Name _____ First Name _____ Work Phone_____

Cell Phone_____ Home Phone _____ Is this person authorized to pick-up youth? _____

2. Last Name _____ First Name _____ Work Phone_____

Cell Phone_____ Home Phone _____ Is this person authorized to pick-up youth? _____

SPONSOR CONSENT I, _____, parent/guardian of _____, give consent for an authorized CYS representative to obtain medical/dental care for my youth in an emergency situation where his/her condition represents a serious or imminent threat to his/her life, health, or wellbeing. I understand that a conscientious effort will be made to notify me prior to such action and the expense, if any, will be paid by me. Treatment at an Army medical facility may be provided without additional consent under the provision of AR 40-3.

1. Does your youth have any special needs (asthma, allergies, ADHD, physical disabilities, dietary restrictions, rescue medications, etc.)? ◯ **YES** ◯ **NO** *(If yes, CYS will send you a Health Screening Tool to be completed and returned within 5 days.)*
2. Can the use of photographs and/or video of your youth to include text, analog and digital media and artwork created by your youth be released to Media and/or used in CYS marketing materials? ◯ **YES** ◯ **NO**
3. Can your youth be transported in a government or commercial vehicle? ◯ **YES** ◯ **NO**
4. Does your youth have permission to access CYS network, the internet or social networking sites? ◯ **YES** ◯ **NO**
5. Have you received a copy of and signed the CYS Acceptable Use Policy and Parental Acknowledgement? ◯ **YES** ◯ **NO**
   Date signed CYS Acceptable Use Policy was returned to Youth Services or Parent Central Services_____

I have reviewed the information on this form and to the best of my knowledge, the information is accurate.

Parent/Guardian Signature _____ Date_____

STAFF TELEPHONIC VERIFICATION Name of verifying staff_____ Date_____

Name of verifying parent _____ Time _____ Special needs? ◯ **YES** ◯ **NO**

If yes to Special Needs, date Health Screening sent to parent _____ Date returned _____ Remarks _____

Date pass issued in CYMS_____ Staff Signature_____

Name and initials of verifying staff Year 2_____ Year 3_____ Year 4_____

ANNUAL RE-REGISTRATION *If yes, explain:*

Year 2 Date _____ Health Changes ◯ YES ◯ NO _____ Parent Signature _____

Year 3 Date _____ Health Changes ◯ YES ◯ NO _____ Parent Signature _____

Year 4 Date _____ Health Changes ◯ YES ◯ NO _____ Parent Signature _____

We look forward to seeing you in our programs and encourage parents to drop by anytime to see the great things happening in our Youth Programs. If you would like more information, please call one of the numbers listed below:

Youth Program Information: Parent Central Services Information:

Additional Information:

1. Youth may attend the regular Youth Programs (no field trips or special events until registration is finalized) as a guest member immediately upon receipt of complete form.
2. CYS staff will validate registration form. If validation is not completed within 5 working days, immediately contact the Program Manager or Outreach Services Director. Youth guest membership will be cancelled if the parent is not available to verify information.
3. Once registration is validated (and, if required, Health Screening Tool is completed and returned), annual pass will be issued to youth.
4. Some special events and field trips may cost a nominal fee, but participation in these events is not mandatory. In the case of field trips, written parental permission must be granted before a youth is allowed to participate.
5. To enroll in a team or individual sports program, a sports physical is required in addition to this registration. Sports fees may also apply.