Parent Central Services Registration Checklist
Tieman 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 FOR REGISTRATION	VERIFICATION
Proof of Eligibility (Active Duty Military/Reservist on Active Duty Orders) Current Active Duty Orders.	
Child's Official Shot Record (fifth grade and below, Homeschool, and Private School)	
Family Care Plans DA5305 (Required for single/dual military and single/dual deployable civilian families) (Due 30 days from enrollment in part/full time programs)	
Proof of Parent(s) Income (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	
Program Information Form 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	
Program Agreement - DA FORM 5226-R	
Child and Family Profile - DA FORM 5224-R	
Liability Waiver Form	
Child Health Assessment/Sports Physical Form (due within 30 days of your registration appointment for children birth through 5th 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)	
Health Screening Tool-1 (To record/evaluate child's allergies, medical/physical conditions, etc. for all children birth through 5th grades and ALL Youth identified as having special needs)	
Medical Action Plan (MAP) Only needed if a child is **diagnosed** 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)	
Child/Adult Care Food Program Child Enrollment Form	
Child Care Center Meal Benefit Income Eligibility Form	
D.O.D Priority Information Agreement	

Comments:_____

_____

_____

_____

Registration completed by:_____ Date:_____

UNITED STATES ARMY
CHILD & YOUTH SERVICES

Reset Form

Child and Youth Services Program Information Form

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Date: _____

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.

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 _____ Home 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 _____

Child's Name: _____ DOB: _____ Grade: _____ School: _____

Child's Name: _____ DOB: _____ Grade: _____ School: _____

Child's Name: _____ DOB: _____ Grade: _____ School: _____

Child's Name: _____ DOB: _____ Grade: _____ School: _____

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? _____

3. Last Name _____ First Name _____ Work Phone_____

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

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 | 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 Rd. Carlisle, PA 17013

PROGRAM SERVICES

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

MON 0630 TO 17300 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 0630 TO 1730 TUES 0630 TO 1730 WED 0630 TO 1730

THURS 0630 TO 1730 FRI 0630 TO 1730 SAT _____ TO _____

SUN _____ TO _____

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

Authorized Closures, Fed. Holidays and Weekends 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 a 30-day advance written notice for a withdrawal from a program may result in the responsibility of payment in full for the bi-monthly fee of the last cycle that occurs within the last date of care.

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:

DD Form 2652 - Total Family Income (TFI) determined category is: _____, charged at a monthly rate of: $_____

MISCELLANEOUS FEES FOR PROGRAM SERVICES ARE AS FOLLOWS:

Late pick-up fees are $1.00 per minute for the first 15 minutes per family, per site. When the family is later than 15 minutes, the family is charged $7.00 per child, per site for the remainder of the hour and then $7.00 per child, per site for each hour thereafter. The Standard Army-wide hourly care rate is $7.00 per hour per child for ALL CDS programs regardless of the Total Family Income (TFI) category.

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 NOT BE REDUCED.

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

FEES WILL BE PAID IN THE FOLLOWING MANNER

Full-day fees are due on the 5th business day of the payment cycle (1st and 15th). A one-time $10.00 per child late payment fee will be assessed on the 6th business day of each missed payment cycle. Failure to pay child care fees can result in removal from care. Hourly care fees will be paid daily upon pick up. The use of leave vacation days are authorized for full-day CDC programs, they must be used in 5-day increments and apply to each valid registration year.

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

Only physician-prescribed medications are permitted within CDS programs. Medication must be prescribed by a physician and have an RX label. A physician or parent must administer the first dose. Children must be on the prescribed medication at least 24 hours before the first dosage is administered by CDS Personnel. DA Form 5225-R (CDS Medical Dispensation Record) must be completed before administration of medication.

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

I WILL PROVIDE THE FOLLOWING TO MEET CDS PROGRAM REQUIREMENTS

Name and phone number of at least two emergency contacts that can pick up within 1 hour of notification or have the ability to contact the sponsor/spouse immediately if needed. Designees must be at least 13 years old. A Health Assessment within 30 days of registration (if no specials needs). A Family Care Plan within 30 days of registration (single/ dual military). A current immunization record for all CDC programs. A clean and well-rested child with appropriate clothing for indoor and outdoor play.

I ACKNOWLEDGE A SHARED RESPONSIBILITY WITH CDS FOR CHILD ABUSE PREVENTION

IAW AR608-10, Para 2-20 and AR 608-18, CDS staff are trained in the prevention and recognition of child abuse and neglect. By law, facility staff must report any suspicion of child maltreatment immediately to the Military Police.

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

-All policies and procedures outlined in the Parent Handbook.
-Enrollment into any CDS program is contingent upon programs successfully meeting the child's needs. If at any time, 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.
-Children with a fever or diarrhea will not be readmitted until the fever or diarrhea has been absent for 24-hrs. Other illnesses require a doctor's statement of readmission.
-In accordance with AER 608-10-1, ill children will be picked up immediately (within an hour) upon notification.
-Children will not bring toys, food, or personal items to the facility without prior approval or appropriate documentation.

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 (YYYY-MM-DD)
ADDRESS *(Include ZIP Code)*	TELEPHONE
DUTY ADDRESS *(Include ZIP Code)*	TELEPHONE

CHILD DATA

NAME *(Last, first, MI)*	NICKNAME	BIRTH DATE (YYYY-MM-DD)

DEVELOPMENTAL TASKS/ACCOMPLISHMENTS FOR INFANTS AND TODDLERS *(Check appropriate blocks)*

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

"This document conforms to the privacy act of 1974: 10 USC 30 31"

LIABILITY WAIVER

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

Sponsor's Name:

Address:

Tel:

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

Reset Form

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's DOB (YYYY-MM-DD)	Spouse's Work Telephone

CHILD HEALTH INFORMATION

Name of Child	Birth Date (YYYY-MM-DD)	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	

Reset Form

EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP)

CYS SERVICES PROGRAMS HEALTH/DEVELOPMENTAL SCREENING

For use of this form, see AR 608-75; the proponent agency is ACSIM.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 3013, Secretary of the Army; 29 U.S.C. 794, Nondiscrimination Under Federal Grants and Programs; DoDI 1342.17 Family Policy; AR 608-75, Exceptional Family Member Program; DoDI 6060.02, Child Development Programs; AR 608-10, Child Development Services.

PRINCIPAL PURPOSE: Information will be used to assist Army activities in their responsibilities in the overall execution of the Army's Exceptional Family Member Program and Child, Youth and School Services Programs.

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 utilize Army Child, Youth and School Services.

FOR POS COMPLETION ONLY

☐ Initial Registration
On waiting list? ☐ Yes ☐ No
Date care needed? _____

☐ Re-registration/already in program
☐ Current Program
☐ Change in Condition

Date in from Patron: _____
Date out to APHN: _____

PART A- GENERAL INFORMATION *(Parent completes)*

Child/Youth's Name	Child/Youth School Grade *(example: 3rd Grade)*	Date of Birth *(YYYY-MM-DD)*	Age

Type of Program Requested *(check all that apply):*

☐ Hourly Care ☐ Full Day Care ☐ Middle School/Teen Program ☐ Summer Camp ☐ Other: _____
☐ Part Day Care ☐ Before/After School Care ☐ SKIES/Instructional Classes ☐ Sports

Sponsor Name	Sponsor Email *(AKO)*	
Spouse Name	Spouse Email	Sponsor DOB (YYYY-MM-DD)

Home Phone	Cell Phone	Sponsor Unit
Home Address		Sponsor Duty Phone

PART B - CHILD / YOUTH MEDICAL / DEVELOPMENTAL CONDITIONS *(check yes or no)*

Does your child/youth have:

1. Asthma/Reactive Airway Disease/Breathing Problems? ☐ Yes ☐ No
   a. Does it require a rescue medication? ☐ Yes ☐ No
2. Allergies? List: ☐ Yes ☐ No
   a. Does it require a rescue medication? ☐ Yes ☐ No
3. Dietary Restrictions? ☐ Yes ☐ No
   ☐ a. Medically-based ☐ b. Religiously-based
4. Diabetes? ☐ Yes ☐ No
5. Epilepsy/Seizures? ☐ Yes ☐ No
6. Attention Deficit/Hyperactivity Disorder (ADD/ADHD)? ☐ Yes ☐ No
   a. Is your child/youth prescribed medication? ☐ Yes ☐ No
7. Diagnosed Behavior/Conduct concerns? ☐ Yes ☐ No
   a. Is your child/youth prescribed medication? ☐ Yes ☐ No
8. Emotional problems/difficulties? ☐ Yes ☐ No
9. Autism Spectrum Disorder? ☐ Yes ☐ No
10. Developmental Disability? ☐ Yes ☐ No
11. Visual problems/difficulties not corrected by glasses/ contacts? ☐ Yes ☐ No
12. Hearing problems/difficulties? ☐ Yes ☐ No
13. Speech/language delays? ☐ Yes ☐ No
14. Other developmental delays? ☐ Yes ☐ No
15. Physical disability? ☐ Yes ☐ No
16. Other medical condition or concerns? If yes, please explain: ☐ Yes ☐ No

PART C - MEDICATIONS

List any medications that are prescribed for your child/youth:

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

Child/Youth's Name: _____

PART D - EARLY INTERVENTION AND SPECIAL EDUCATION

Does your child/youth receive special services/therapies? ☐ Yes ☐ No
If yes, please specify:

Does your child/youth have an:

a. Individualized Education Plan (IEP) ☐ Yes ☐ No

b. Individualized Family Service Plan (IFSP) ☐ Yes ☐ No

c. 504 Plan ☐ Yes ☐ No

PART E - EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) ENROLLMENT

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

If you have answered NO to all the questions above or YES to ONLY Part B, 3b., sign and date below, indicating that the information above is accurate and complete to the best of your knowledge.

Printed Name of Parent/Personal Representative of Child/Youth	Signature of Parent/Personal Representative of Child/Youth	Date *(YYYY-MM-DD)*

If you answered YES to any of the questions above (OTHER THAN PART B, 3b.), complete Part F below.

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 status please notify CYS Services immediately.

PART F - RELEASE OF INFORMATION

Is this child/youth currently covered by TRICARE or other military health care? ☐ Yes ☐ No

I authorize _____ to release any medical information regarding my child
(name of Medical Treatment Facility or physician's practice)

_____ to the _____
(name of child) *(name of installation)*

Child, Youth & School (CYS) services and Multidisciplinary Inclusion Action Team (MIAT) personnel, are necessary to conduct a MIAT 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 MIAT team 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 of Parent/Personal Representative of Child/Youth	Signature of Parent/Personal Representative of Child/Youth	Date *(YYYY-MM-DD)*

Child and Adult Care Food Program **Sponsor:_____**
Child Enrollment Form (Sample) **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 NAME BIRTH DATE AGE	☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
		Other:								
		Enrollment Date:				**Withdrawal Date:**				
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**		
		☐ *Same Times as Above*								
		AM	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
SECOND CHILD NAME BIRTH DATE AGE	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
		Other:								
		Enrollment Date:				**Withdrawal Date:**				
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**		
		☐ *Same Times as Above*								
		AM	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
THIRD CHILD NAME BIRTH DATE AGE	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
		Other:								
		Enrollment Date:				**Withdrawal Date:**				
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**		
		☐ *Same Times as Above*								
		AM	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
FOURTH CHILD NAME BIRTH DATE AGE	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
		Other:								
		Enrollment Date:				**Withdrawal Date:**				
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**		
		☐ *Same Times as Above*								
		AM	**PM**	**TIME**	**AM**	**PM**	**TIME**	**LEAVES CENTER**	**RETURNS TO CENTER**	
FIFTH CHILD NAME BIRTH DATE AGE	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
		Other:								
		Enrollment Date:				**Withdrawal Date:**				

Signature _____ _____ _____

Signature of Parent or Guardian *Date (YYYY-MM-DD)* *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.

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

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**			
	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	$23,828
2	$32,227
3	$40,626
4	$49,025
5	$57,424
6	$65,823
7	$74,222
8	$82,621
Each additional person:	+$8,399

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."

DEPARTMENT OF THE ARMY
US ARMY INSTALLATION MANAGEMENT COMMAND
2405 GUN SHED ROAD
JOINT BASE SAN ANTONIO FORT SAM HOUSTON, TX 78234-1223

Dear Family,

JUL 20 2020

This letter is to inform you of Department of Defense changes to priorities for child care and how they may impact you. The intent of these changes is to ensure priority access to child care for military members.

The new priority system becomes effective on September 1, 2020 and applies to all new requests for child care and to children currently enrolled in full-day and regularly scheduled school-age care in military Child Development Centers, 24/7 Child Development Centers, School Age Care centers, and Family Child Care Homes.

The updated Department of Defense child care priorities are listed at the enclosure. All child care placement offers must be made through militarychildcare.com in accordance with the new priorities. Children will be placed on a wait list, according to priority, when there is not sufficient child care capacity to meet demand.

Children may be supplanted from care by children in higher priority categories whose wait times exceed 45-days beyond the date care is needed. Enclosure provides category priorities and details on patrons who may be supplanted.

Families of children who are supplanted will receive 45-day notices and may request new placements, according to their priorities, on militarychildcare.com.

Families receiving notification of supplanting may be eligible for Army Fee Assistance to help pay the cost of off-post child care and may receive enhanced referrals to help them find off-post child care. Fee assistance enrollment is in accordance with the Department of Defense priority system when there is a wait list based on funding availability. Patrons must meet eligibility requirements for Army Fee Assistance. Child and Youth Services professional are available to support and answer any questions.

Additionally, providers must meet qualification requirements and be approved. More information is available at: https://www.childcareaware.org/fee-assistancerespite/military-families/army/.

Please contact your local Child and Youth Services Program Manager for more information.

Sincerely,

Douglas M. Gabram
Lieutenant General, U.S. Army
Commanding

Enclosure

Department of Defense Priorities for Child Care

Priority 1A, CDP Direct Care Staff. The children of CDP Direct Care Staff are placed into care ahead of all other eligible patrons.

CDP Direct Care Staff are employees, paid from either Appropriated Funds (APF) or Non-appropriated Funds (NAF) responsible for the care of children enrolled in CDCs and SACs. CDP Direct Care staff are staff members whose main responsibility focuses on providing care to children and youth.

Priority 1A patrons may not be supplanted.

Priority 1B, in the following order of precedence: (a) Single or Dual Active Duty Members, (b) Single or Dual Guard or Reserve members on Active Duty or Inactive Duty Training Status, (c) Active Duty with Full-time Working Spouses, and (d) Guard or Reserve members on Active Duty or Inactive Duty training status with full-time working spouses.

Children of 1B priority patrons will be placed into care ahead of other eligible patrons, except Priority 1A patrons.

Priority 1B patrons may not be supplanted.

Priority 1C, in the following order of precedence: (a) Active Duty Members with part-time working spouses or spouses seeking employment and (b) Guard or Reserve members on Active Duty or Inactive Duty training status with a part-time working spouses or spouses seeking employment.

Children of 1C priority patrons will be placed into care ahead of all other eligible patrons, with the exception of Priorities 1A and 1B.

Priority 1C patrons may be supplanted by eligible patrons in Priority 1A or 1B whose anticipated placement time exceeds 45 days beyond the dates care is needed, as indicated in militarychildcare.com.

Priority 1D, in the following order of precedence: (a) Active Duty members with spouses enrolled full time in post-secondary institutions, or (b) Guard and Reserve members on Active Duty or Inactive Duty training status with spouses enrolled full time in post-secondary institutions.

Children of 1D priority patrons will be placed into care ahead of other eligible patrons, with the exception of Priorities 1A, 1B, and 1C.

Priority 1D patrons may be supplanted by eligible patrons in Priority 1A, 1B, or 1C whose anticipated placement time exceeds 45 days beyond dates care is needed, as indicated in militarychildcare.com.

Priority 2, DoD Civilians. Children of DoD civilians will be placed in the following order of precedence: (a) Single or dual DoD Civilian Employees, and (b) DoD Civilian Employees with full-time working spouses.

DoD civilian patrons may only be supplanted by eligible Priority 1A or 1B patrons whose anticipated placement time exceeds 45 days beyond dates care needed as indicated in militarychildcare.com.

Priority 3, Space Available. When Priority 1 and 2 patrons are placed into care, CYS Services may place other eligible patrons not identified in Priority 1 and 2 into space available care.

Space Available patrons will be placed in the following order of precedence: (a) Active Duty with non-working spouses, (b) DoD Civilian employees with spouses seeking employment, (c) DoD Civilian Employees with spouses enrolled in fulltime post-secondary education programs, (d) Gold Star spouses, (e) DoD Contractors, and (f) other eligible patrons.

Space available patrons may be supplanted by priority 1 or 2 patrons whose anticipated placement times exceeds 45 days beyond dates care needed as indicated in militarychildcare.com.

Sponsor's name: _____

Sponsor's signature: _____

Date: _____

Encl