

NEW REGISTRATION W/SIBLING



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 FOR REGISTRATION	VERIFICATION
Child's Official Shot Record (fifth grade and below, Homeschool, and Private School)	
Child and Family Profile - DA FORM 5224-R	
Child Health Assessment/Sports Physical Form (due within 30 days of your registration appointment for children birth through 5 th 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 5 th 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)	
Liability Waiver Form	

Comments: _____

Registration completed by: _____ 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 (<i>Last, first, MI</i>)	DATE
ADDRESS (<i>Include ZIP Code</i>)	TELEPHONE
DUTY ADDRESS (<i>Include ZIP Code</i>)	TELEPHONE

CHILD DATA

NAME (<i>Last, first, MI</i>)	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"/> ALONE	<input type="checkbox"/> MODERATE <input type="checkbox"/> HIGH <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 (<i>Comments</i>) <input type="checkbox"/> YES <input type="checkbox"/> NO	BEDTIME (<i>Time, etc.</i>)

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

LIABILITY WAIVER

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

Sponsor's Name:

Tel:

Address:

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

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

CHILD HEALTH INFORMATION

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

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:	/	Visual Acuity Right / Left /	Tested with / without glasses	
P:				
	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: <input type="checkbox"/> Yes <input type="checkbox"/> No				
PARTICIPATION RECOMMENDATIONS				
<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

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? <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

HASPS Renewal (Not Part of the Sports Physical)

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	

**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

<input type="checkbox"/> Initial Registration	<input type="checkbox"/> Re-registration/already in program	Date in from Patron: _____
On waiting list? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Current Program	Date out to APHN: _____
Date care needed? _____	<input type="checkbox"/> Change in Condition	

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):			
<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"/> Part Day Care	<input type="checkbox"/> Before/After School Care	<input type="checkbox"/> SKIES/Instructional Classes	<input type="checkbox"/> Sports
Sponsor Name		Sponsor Email (AKO)	
Spouse Name		Spouse Email	
Home 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Emotional problems/difficulties?	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Does it require a rescue medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Autism Spectrum Disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Allergies? List:	<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Developmental Disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Does it require a rescue medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Visual problems/difficulties not corrected by glasses/contacts?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Dietary Restrictions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Hearing problems/difficulties?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> a. Medically-based <input type="checkbox"/> b. Religiously-based		13. Speech/language delays?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	14. Other developmental delays?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Epilepsy/Seizures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	15. Physical disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Attention Deficit/Hyperactivity Disorder (ADD/ADHD)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	16. Other medical condition or concerns? If yes, please explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Is your child/youth prescribed medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
7. Diagnosed Behavior/Conduct concerns?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
a. Is your child/youth prescribed medication?	<input type="checkbox"/> Yes <input type="checkbox"/> 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)
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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)
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