CDC and SAC Sports Only

Sports Registration Checklist
McConnell Youth Center

YS Front Desk Phone: 717.245.4555

Sport's Director: 717.245.3354

Parent Central Phone: 717.245.3801

If you need to utilize other CYS programs to include, **Hourly Care, Full day/Part day Care, Before/After School,** You must complete the CYS Program Registration Packet.

Please contact Parent Central Services to make an appointment.

THIS PACKET IS FOR SPORTS REGISTRATION ONLY Parent's Initial_____

ITEMS/INFORMATION FOR REGISTRATION	VERIFICATION
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*	
Child Health Assessment/Sports Physical Form (Sports Physical 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)	
Child's Official Shot Record (fifth grade and below, Homeschool, and Private School	
Liability Waiver	

CHILDREN WITH SPECIAL NEEDS ONLY	VERIFICATION
Medical Action Plan (MAP)(For Children with Medical/Nutritional Condition)	
Other Documents (For Children With Learning Disability, Developmental, and Behavior Concerns)	

Comments:_____

_____

_____

_____

_____

_____

Parent's Signature:_____Date:_____

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? _____

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)*

"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