Child and Youth Services

Sports Only MST Reg.

Youth Program Registration & Sponsor Consent

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.

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** ☐ Yes ☐ No	**Signature of Parent or Guardian**
Year 3 Date	**Health Status Changed** ☐ Yes ☐ No	**Signature of Parent or Guardian**