

**FORT MONROE
Child & Youth Services
PROGRAM REGISTRATION FORM**

Revision 2.0 May-2007

Registration Date: _____

SPONSOR: _____
 Rank/Grade _____ Last _____ First _____ Branch of Service: _____
 Home Address: _____
 Street _____ Cell Phone #: () _____
 City _____ Zip Code _____ Hm Phone #: () _____
 On/Off Post (Please circle one) _____ Dual Military: Y / N (circle one)
 Employer/Unit: _____ Single Parent: Y / N (circle one)
 Mission Essential: Y / N (circle one)
 Deployed: Y / N (circle one)
 Address: _____ Wk Phone #: _____ Time Frame: _____
 E-mail Address: _____ Status: Active / Retired / DA Civilian / Civilian
 (Please circle one)

SPOUSE: _____
 Rank/Grade _____ Last _____ First _____ Branch of Service: _____
 Home Address: _____
 Street _____ Cell Phone #: () _____
 City _____ Zip Code _____ Hm Phone #: () _____
 On/Off Post (Please circle one) _____ Dual Military: Y / N (circle one)
 Employer/Unit: _____ Mission Essential: Y / N (circle one)
 Deployed: Y / N (circle one)
 Address: _____ Wk Phone #: _____ Time Frame: _____
 E-mail Address: _____ Status: Active / Retired / DA Civilian / Civilian
 (Please circle one)

CHILD #1: _____
 Last _____ First _____ M.I. _____
 DOB: _____ Gender: M / F (Please circle one) School: _____
 Medical/ Educational Concerns: _____ Grade: _____
 Allergies: _____
 Ethnic Background: White Black Asian Hispanic Native American Multiracial
 (Please circle one)
 ENROLLED IN: (please circle) CDC SAS MS/IT FCC SPORTS STACC OTHER
 Program: _____ Start Date: _____
 Room #/Provider: _____ Orientation Date: _____

CHILD #2: _____
 Last _____ First _____ M.I. _____
 DOB: _____ Gender: M / F (Please circle one) School: _____
 Medical/ Educational Concerns: _____ Grade: _____
 Allergies: _____
 Ethnic Background: White Black Asian Hispanic Native American Multiracial
 (Please circle one)
 ENROLLED IN: (please circle) CDC SAS MS/IT FCC SPORTS STACC OTHER
 Program: _____ Start Date: _____
 Room #/Provider: _____ Orientation Date: _____

CHILD #3: _____
 Last _____ First _____ M.I. _____
 DOB: _____ Gender: M / F (Please circle one) School: _____
 Medical/ Educational Concerns: _____ Grade: _____
 Allergies: _____
 Ethnic Background: White Black Asian Hispanic Native American Multiracial
 (Please circle one)
 ENROLLED IN: (please circle) CDC SAS MS/IT FCC SPORTS STACC OTHER
 Program: _____ Start Date: _____
 Room #/Provider: _____ Orientation Date: _____

EMERGENCY NOTIFICATION DESIGNEES(S):

Name (1): _____ Home Phone: () _____
 Child Release Designee: Yes / No (circle one) Duty/Work Phone: () _____
 Cell Phone: () _____

Name (2): _____ Home Phone: () _____
 Child Release Designee: Yes / No (circle one) Duty/Work Phone: () _____
 Cell Phone: () _____

Name (3): _____ Home Phone: () _____
 Child Release Designee: Yes / No (circle one) Duty/Work Phone: () _____
 Cell Phone: () _____

Child and Youth Services Registration Form

Sponsor: (last name) _____ (first) _____
Child: (last name) _____ (first) _____

PARENT/GUARDIAN CONSENT PERMISSION:

I, _____ Parent/Guardian of _____

in consideration for being allowed to participate in Child & Youth Services, hereby release the Fort Monroe VA 23651 Morale Welfare Recreation (MWR) activities and the United States Government from any and all liabilities or claims arising from my own participation. I agree that I will never prosecute or in any way aid in prosecuting any demand, claim, or suit against the United States Government for any loss, damage or injury to my person or property that may occur from any cause whatsoever as a result of taking part in this activity. I also understand and agree that I may be held liable for any damage or loss to the United States Government that is caused by my gross negligence, willful misconduct, or fraud.

In addition, I consent to the following:

	Yes	No
1) To use audio/video/photos of my child for media purposes with prior knowledge.	_____	_____
2) Participate in field trips (on or off post) with prior knowledge.	_____	_____
3) Use of Government or commercial vehicle transportation	_____	_____
4) Transportation in a private vehicle is authorized, for emergency's.	_____	_____
5) Independantly participate in athletic events, classes, youth clubs, walking to and from school visiting friends, 4-H, BGCA or other activities such as:	_____	_____

MEDICAL CONSENT

I, _____ Parent/Guardian of _____ give consent for an authorized 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. I understand that a conscientious effort will be made to notify me before such action. I will pay any expenses incurred. Treatment at an Army medical facility may be provided without additional consent under provision of AR 40-3, paragraph 2-24b.

30 DAY SUSPENSE CHECKLIST:

I understand that I have thirty (30) days to submit the documents below and that these documents cannot be waived. Failure to do so will result in my child being denied services from any / all CYS programs

_____ Health Assessment _____ Family Care Plan-DA 5305-R (or branch equivalent)
(due date) *(due date)* *(as prescribed by AR 600-20 and AR 608-10)*

Sole and Dual Military Care Plan

I understand that as prescribed by AR 600-20 and AR 608-10, I am required to maintain an accurate Family Care Plan for my dependent child. I am also aware that I must provide CYS with a complete, approved, and verifiable DA form 5303-R within 30 days from the date of registration or service may be denied. I understand that I will provide updated information annually or more frequently in order to maintain accurate information.

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10 United States Code, Section 3013

PRINCIPLE PURPOSE(S): To provide child and family program eligibility and background information; sponsor consent for access to emergency medical care; data required by USDA food program.

ROUTINE USES: 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. 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 structure.

DISCLOSURE: Disclosure of requested information is voluntary, however, if information is not provided, individuals may not be allowed to participate in CYS programs.

DECLARATION OF NONDISCRIMINATION

Services will be made available to all children in attendance, without regard to race, color, religion, national origin, ancestry, or sex, within the limits of AR 608-10. CYS programs participating in the Food Program shall offer meals without physical segregation, or discrimination against any child regardless of ability to pay.

PARENT SIGNATURE:

I have reviewed the attached household and family information file. To the best of my knowledge, the information on this form and contained therein is accurate and complete.

Parent Signature

Date

**CHILD AND YOUTH SERVICES (CYS)
FORT MONROE**

**AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION TO
SPECIAL NEEDS RESOURCE TEAM (SNRT), and CYS Programs**

Authority – Public Law 104-191, “Health Insurance Portability and Accountability Act (HIPPA),” August, 21, 1996.

I authorize **Child and Youth Services** to release my patient information to the CYS Special Needs Resource Team (SNRT) which will be used to provide the most appropriate care for my child.

1. The authorization applies to SNRT notes, asthma action plans, physicals, medical notes, immunization records, school education plans and intervention program plans. Only representatives from the CYS programs responsible to the CYS SNRT will have access to the information.
2. Start Date: the authorization start date is the date that you sign this form authorizing release of information.
3. Expiration Date: The authorization shall continue until enrollment in the CYS program is no longer necessary according to service specific criteria.

CYS Program:

Any and all medical information submitted by the parent will be maintained in the child’s CYS records. This and all medical information will be securely locked with limited access to medical information.

I understand that:

1. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facilities where my records are kept. I am aware that if I later revoke the authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
2. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
3. I have the right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR 164.524. I request and authorize the named provider/treatment facility to release the information described above to the named individual/organization.

Child’s Name	
Signature of Sponsor/Guardian	Date
CYS Staff Representative	Date

ARMY CHILD AND YOUTH SERVICES HEALTH SCREENING TOOL

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

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.

Part A - General Information

1. Child's Name		2. Date of birth (YYYYMMDD)
3. Family member prefix		
4. Type of placement requested		5. Date (YYYYMMDD)
6. Sponsor name		7. SSN (last four digits)
8. Spouse name		
9. Home phone	10. Duty phone	11. Cell phone

Part B - Identification of Child/Youth Condition/Restrictions

Child has any of the following conditions/restrictions: (Check yes or no)

1. Allergies	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
a. Life threatening reaction	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
b. Epi-pen required	<input type="checkbox"/> No	<input type="checkbox"/> Yes
c. Other allergic reactions (hives, rash, diarrhea)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
2. Asthma reactive airway disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
a. Triggers exist for child's asthma attacks (stress, environmental, exercise)	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
b. Child routinely (greater than 10 days per month/four months per year) uses inhaled anti-inflammatory agents and/or bronchodilators	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
c. Child has taken steroids during the past year (prednisone, prednisolone)	<input type="checkbox"/> No	<input type="checkbox"/> Yes (indicate number of days in past year)

d. Child has experienced unconsciousness or seizures associated with asthma attacks	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
e. Child required an urgent visit to emergency room or clinic for acute asthma within the last 12 months	<input type="checkbox"/> No	<input type="checkbox"/> Yes (indicate number of visits in the past year)
f. Child has been hospitalized for asthma related condition in the past six months	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
3. Attention Deficit Disorder (ADD)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
a. ADD with hyperactivity	<input type="checkbox"/> No	<input type="checkbox"/> Yes
b. Is not well controlled with medication	<input type="checkbox"/> No	<input type="checkbox"/> Yes (not well controlled)
c. Behavioral/conduct concerns	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
4. Autism	<input type="checkbox"/> No	<input type="checkbox"/> Yes
5. Behavioral/conduct concerns (for example, oppositional defiant disorder, anxiety disorder, school phobias)	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
6. Blindness/visual problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
7. Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
8. Emotional problems that require care by a psychiatrist, psychologist or social worker	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
9. Epilepsy	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
10. Hearing problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
11. Heart problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
12. Kidney problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
13. Speech/language delay	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
14. Physical disability	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
15. Dietary restrictions	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)

16. Assistance with activities of daily living
 No Yes (explain)

17. Other conditions
 No Yes (specify and explain)

Part C - Medications

Child is on medications on a regular basis
 No Yes (If yes, please list medications and indicate which require administration during child care hours.)

Part D - Early Intervention and Special Education

Child has an Individualized Family Service Plan (IFSP), Individualized Education Plan (IEP) or 504 plan
 No Yes

Part E - Exceptional Family Member Program (EFMP) Enrollment

Child is enrolled in the EFMP
 No Yes (specify for what condition)

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 CYS/SNAP in reliance 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.

Signature of Parent or Personal Representative of Child

Date (YYYYMMDD)

CHILD AND YOUTH SERVICES HEALTH ASSESSMENT / SPORTS PHYSICAL

DATA REQUIRED BY THE PRIVACY ACT OF 1994			
<p>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.</p>			
<p>INSTRUCTIONS: Health Assessment complete sections A & C; Sports Physicals complete sections A, B & C.</p>			
PART A			
Name of Sponsor		Home Telephone	Duty/Work Telephone
Sponsor Unit / Work Address		Cell Telephone	Spouse's Work Telephone
Sponsor SSN			
CHILD HEALTH INFORMATION			
Name of Child		Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
<p>Does your child have ongoing medical concerns? (If Yes, explain circumstances and current status)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>Is your child enrolled in Exceptional Family Member Program? (If Yes, explain)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
MEDICAL HISTORY			
	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. Other problems (list below)
13. Chest pain with exercise			
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: SPORTS PHYSICAL				
Medical Staff Assessment (Completed by licensed independent practitioner)				
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"/> PA 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 Signature
Date	Type or print name of Parent or Guardian	Signature of Parent or Guardian

Health Assessment Re-Certification

Date	Health Status Changed	Signature of Parent or Guardian
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Date	Health Status Changed	Signature of Parent or Guardian
	<input type="checkbox"/> Yes <input type="checkbox"/> No	

FORT MONROE
CHILD AND YOUTH SERVICES
SUPPLEMENTAL PROGRAMS AND SERVICES

**FAMILY CARE PLAN INFORMATION
CONSOLIDATION SHEET
For Single/Dual Military Parent(s)**

CHILD'S/CHILDREN'S NAME(S) _____

PARENT'S NAME and RANK _____

DUTY ASSIGNMENT _____

PHONE _____

**DUAL MILITARY PARENT'S
NAME and RANK** _____

DUTY ASSIGNMENT _____

PHONE _____

**TEMPORARY CUSTODY AND, IF NEEDED, AUTHORITY TO TRANSPORT
CHILD/CHILDREN TO PRINCIPAL DESIGNEE (GUARDIAN)**

NAME _____

ADDRESS _____

PHONE _____

PRINCIPAL DESIGNEE (GUARDIAN)

NAME _____

ADDRESS _____

PHONE _____

PARENT'S SIGNATURE and DATE _____