



U.S. Army Child, Youth
& School Services

Parent Central Services

Registration Requirements for CYS Services Programs

- ❖ Official Shot Record with Negative TB test results (12 months and older)
- ❖ CYS Services Health Assessment (due within 30 days of registration)
 - ❖ **If your child has any allergies or special needs (i.e. asthma, diet restrictions, seizures, ADHD, Diabetes, Autism, eczema), additional forms will need to be submitted. Contact one of our offices for details.**
- ❖ Two local emergency contacts (other than parents or legal guardian)
- ❖ Proof of total family income (last end of month LES and/or pay stubs)
- ❖ Family Care Plan for dual/single active duty members

*** Parent/Legal Guardian must attend an orientation at the program (CDC, SAC, or Youth Center) prior to utilizing childcare services. ***

Aliamanu Military Reservation (AMR)

Bougainville Loop, Bldg 1782

Phone: 808-833-5393

Hours: 0800-1700

Walk-ins: 0800-1200

Appointments: 1300-1600

Schofield Barracks

241 Hewitt Street Bldg 1283

Phone: 808-655-5314/808-655-8380

Hours: 0730-1700

Walk-ins: 0730-1100

Appointments: 1200-1500

PROGRAM REGISTRATION FORM
Child & Youth School Services

SPONSOR: _____ **Cell Phone #:** _____
Grade Last First

Home Address: _____
Include Zip Code _____
Dual Military: Y/N On Post/Off Post
(circle one) (circle one)

Duty/Work Address: _____
Include Zip Code _____
AKO or E-Mail Address: _____ Work Phone: _____

Total Family Size: _____ Status: Active/Retired/DA Civillan/Civillian (circle one)

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SPOUSE: _____ **Cell Phone #:** _____
Grade Last First

Duty/Work or College Address: _____
Include Zipcode _____
AKO or E-Mail Address: _____ Work Phone: _____
Status: Active/Retired/DA Civillan/Civillian (circle one)

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Child: _____
Last First M.I.
D.O.B.: _____ **Gender:** Male / Female (Circle One) **School:** _____

Medical Concerns: _____
Allergies: _____

.....
Child: _____
Last First M.I.
D.O.B.: _____ **Gender:** Male / Female (Circle One) **School:** _____

Medical Concerns: _____
Allergies: _____

.....
Child: _____
Last First M.I.
D.O.B.: _____ **Gender:** Male / Female (Circle One) **School:** _____

Medical Concerns: _____
Allergies: _____

.....
Child: _____
Last First M.I.
D.O.B.: _____ **Gender:** Male / Female (Circle One) **School:** _____

Medical Concerns: _____
Allergies: _____

EMERGENCY NOTIFICATION DESIGNEES:

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

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

APPLICATION FOR DEPARTMENT OF DEFENSE CHILD CARE FEES

(Read Instructions on back before completing form.)

OMB No. 0704-0515
OMB approval expires
May 31, 2017

The public reporting burden for this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Service Directorate, Information Management Division, 4800 Mark Center Drive, Alexandria, VA 22350-3100 (0704-0515). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

**PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS. RETURN COMPLETED FORM TO:
OFFICE OF FAMILY POLICY/CHILDREN AND YOUTH, 4800 MARK CENTER DRIVE, SUITE 03G15, ALEXANDRIA, VA 22350-1400**

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 3013, Secretary of the Army; 10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. 5041, Headquarters, Marine Corps; 10 U.S.C. 8013, Secretary of the Air Force; DoD Instruction 6060.02, Child Development Programs; Army Regulation 608-10, Child Development Services; OPNAV Instruction 1700.9 series, Child and Youth Programs; Marine Corps Order P1710.30E, Children, Youth, and Teen Program (CYTP); Air Force Instruction 34-248, Child Development Programs; and Air Force Instruction 34-249, Youth Programs, and 34-276, Family Child Care.

PRINCIPAL PURPOSE(S): To collect total family income to determine child care fees. When completed, records are covered by one of the appropriate SORNs: Department of the Army: <http://dpclo.defense.gov/privacy/SORNs/index/tabid/5915/article/6160/a0608-10-clsc.aspx>; Department of the Navy: <http://dpclo.defense.gov/privacy/SORNs/index/tabid/5915/article/6527/nm01754-3.aspx>; Department of the Air Force: <http://dpclo.defense.gov/privacy/SORNs/index/DODwideSORNArticleView/tabid/6797/Article/5793/034-af-sva-c.aspx>

ROUTINE USE(S): Department of the Army records may be disclosed to civilian health and welfare departments/agencies in emergencies. Department of the Navy records may be disclosed to local, state and Federal officials involved in child care services, if required, in the performance of their official duties relating to child abuse reporting and investigations. Department of the Air Force records may be disclosed to civilian health and welfare departments/agencies in emergency situations. DoD Blanket Routine Uses 1 (Law Enforcement), 4 (Congressional Inquiries), 6 (Required by International Agreement), 9 (Department of Justice for Litigation), 12 (National Archives and Records Administration), and 15 (Data Breach Remediation) specifically apply to this system. Other DoD Blanket Routine Uses found at <http://dpclo.defense.gov/Privacy/SORNs/index/BlanketRoutineUses.aspx> may apply to these records. Any release under a blanket routine use will be compatible with the purpose of the collection.

DISCLOSURE: Voluntary; however, failure to furnish all requested information will result in application of the highest fee range.

SECTION I - DEPENDENT CHILDREN

1. NAME OF EACH CHILD (LAST, First, Middle Initial)	2. DATE OF BIRTH (YYYYMMDD)	3. AGE	4. CARE REQUESTED (OR ENROLLED)
a.			
b.			
c.			
d.			
e.			

SECTION II - ANNUAL FAMILY INCOME

5. SPONSOR

a. NAME (LAST, First, Middle Initial) _____ b. YEARS OF MILITARY/CIVIL SERVICE _____

c. INCOME

(1) Income Data	(2) Basic Allowance for Housing (BAH)	(3) Basic Subsistence Allowance	(4) Other Earned Income	(5) Total Income - Sponsor (To be completed by Program Staff)

6. SPOUSE OR OTHER ADULT LIVING IN THE HOME

a. NAME (LAST, First, Middle Initial) _____ b. INCOME _____

7. OTHER EARNED INCOME _____ **8. TOTAL INCOME** (Include income from Blocks 5, 6, and 7. To be completed by Program Staff.) _____

SECTION III - CERTIFICATION OF SPONSOR/DESIGNEE

(Required for Category I - IX. Please read the following statement carefully before signing.)

I certify that all of the above information is true and correct and that all family income of the spouse and sponsor is reported. I understand that this information is being given in order to determine child care fees to be paid and that Federal funds are used to subsidize the cost of child care. I also understand that the installation commander may verify the information on the application; and that deliberate misrepresentation of this information may subject me to prosecution under applicable State and Federal laws. See 18 U.S.C. Section 1001.

9. SIGNATURE OF SPONSOR _____	10. SIGNATURE OF SPOUSE _____	11. DATE SIGNED (YYYYMMDD) _____
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SECTION IV - FOR CHILD DEVELOPMENT PROGRAM USE ONLY

12. CATEGORY OF APPROVAL _____	13. AUTHORIZED FEES _____	14. DATE OF APPROVAL (YYYYMMDD) _____	15. NAME OF CHILD DEVELOPMENT PROGRAM OFFICIAL _____
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**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.

Installation: _____

SNAP Case Number: _____

PROOF

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

Re-registration/already in program

Date in from Patron: _____

On waiting list? Yes No

Current Program

Date out to APHN: _____

Date care needed? _____

Change in Condition

PART A - GENERAL INFORMATION (Parent completes)

Child/Youth's Name	Child/Youth School Grade (example: 3rd Grade)	Date of Birth (YYYYMMDD)	Age
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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)	Sponsor SSN (Last 4 digits)
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Spouse Name	Spouse Email	Sponsor DOB
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Home Phone	Cell Phone	Sponsor Unit
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Home Address	Sponsor Duty Phone
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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 a. Does it require a rescue medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	8. Emotional problems/difficulties? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Allergies? <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
3. Dietary Restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> a. Medically-based <input type="checkbox"/> b. Religiously-based	10. Developmental Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Diabetes? <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
5. Epilepsy/Seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No	12. Hearing problems/difficulties? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Attention Deficit/Hyperactivity Disorder (ADD/ADHD)? <input type="checkbox"/> Yes <input type="checkbox"/> No a. Is your child/youth prescribed medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	13. Speech/language delays? <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	14. Other developmental delays? <input type="checkbox"/> Yes <input type="checkbox"/> No
	15. Physical disability? <input type="checkbox"/> Yes <input type="checkbox"/> No
	16. Other medical condition or concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain

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 (YYYYMMDD)
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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 (YYYYMMDD)
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Child/Youth's Name: _____

PART G - ARMY PUBLIC HEALTH NURSE (APHN) CASE REVIEW

Medical Records Reviewed? Yes No Not Available

Special Needs/Diagnosis:

Medical History (Applicable to Special Needs/Diagnosis)

Training Required for CYS Staff/FCC Provider (detail type of training, who will provide the training and projected timeline)

Recommendation Summary (if additional space is needed please add a continuation page).

REVIEWED (check all that apply):

Allergy MAP Diabetes MAP Epilepsy/Seizure MAP Respiratory MAP Special Diet Statement

MULTIDISCIPLINARY INCLUSION ACTION TEAM REQUIRED:

Administrative Modified Full Annual Review

APHN Printed Name or Stamp

APHN Signature

Date (YYYYMMDD)

Date Received by APHN (YYYYMMDD)

Date Returned to Parent Central Services/EFMP (YYYYMMDD)

**Health Assessment / Sports Physical Statement (HASPS)
for CYS SERVICES
ENROLLEMENT, Renewal & SPORTS Physical Requirements**

Revised 12Jan 10

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 SSN	Spouse's Work Telephone
CHILD HEALTH INFORMATION			
Name of Child		Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Does your child have ongoing medical concerns? (If Yes, explain circumstances and current status) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is your child enrolled in Exceptional Family Member Program? (If Yes, explain) <input type="checkbox"/> Yes <input type="checkbox"/> 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? 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
	<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	