YS REGISTRATION CHECKLIST

NAME (Last, First, Middle Initial)	TOUR STATUS CS ☐ NCS ☐	GENDER Male ☐ Female ☐
MEDICAL PROBLEMS/ALLERGIES	DATE OF BIRTH	

Sponsor's E-Mail:

Date of Registration:

	Yes	No	Date	Comments
Registration Form (DA Form 4719-R)				
*Health Assessment/Sports Physical Form				
*Immunization Record				
Youth Rules of Conduct/Computer Lab Consent Agreement				
Health Screening Tool (DA Form 7625-1)				
Sponsor's order or Letter of employment				

Central Enrollment Registry: 0900-1800, Mon - Fri (Sat, Sun & U.S. Holiday Closed)

Phone #764-5298, Fax #764-5424

Camp Walker Youth Service Phone #764-5721

CHILD DEVELOPMENT SERVICES *(CDS)* REGISTRATION CARD

For use of this form, see AR 608-10; the proponent agency is ACSIM.

DATE

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY:	Title 10, United States Code, Section 3013
PRINCIPAL 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 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 structures.
DISCLOSURE:	Disclosure of requested information is voluntary, however, if information is not provided, individuals may not be allowed to participate in CDS 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. CDS programs participating in the USDA Food Program shall offer meals without physical segregation of, or discrimination against any child regardless of ability to pay.

NAME OF SPONSOR *(Last, first, MI)*		GRADE	SERVICE *(Check One)* ☐ ACT ☐ RET ☐ CIV	SOLE PARENT ☐ YES ☒ NO
HOME ADDRESS OF SPONSOR *(Include ZIP Code)*	ON POST ☐	HOME PHONE	DUTY/EMPLOYER ADDRESS *(Include ZIP Code)*	
	OFF POST ☒	DUTY PHONE		
NAME OF SPOUSE *(Last, first, MI)*		GRADE	SERVICE *(Check One)* ☐ ACT ☐ RET ☐ CIV	DUAL MILITARY SPONSOR ☐
HOME ADDRESS OF SPOUSE *(Include ZIP Code)*	ON POST ☐	HOME PHONE	DUTY/EMPLOYER ADDRESS *(Include ZIP Code)*	
	OFF POST ☒	DUTY PHONE		
EMERGENCY NOTIFICATION DESIGNEE	HOME PHONE	DUTY PHONE	CHILD RELEASE DESIGNEE	
FAMILY SIZE / GROSS INCOME	USDA CATEGORY *(Check One)* ☒ FULL ☐ REDUCED ☐ PAID		MULTIPLE CHILD DISCOUNT ☐ FD ☐ PD ☐ HR ☐ FCC ☐ N/A	

CDS PROGRAM RATES

B/A SCHOOL ☐ FULL DAY ☐ PRESCHOOL ☐ HOURLY ☐ FCC HOME ☐

NAME OF CHILD *(Last, first, MI)*			NAME OF CHILD *(Last, first, MI)*			NAME OF CHILD *(Last, first, MI)*		
PHYS EXAM DATE	BIRTH DATE	SEX	PHYS EXAM DATE	BIRTH DATE	SEX	PHYS EXAM DATE	BIRTH DATE	SEX

IMMUNIZATION DATES				IMMUNIZATION DATES				IMMUNIZATION DATES			
DPT				DPT				DPT			
TOPV				TOPV				TOPV			
MMR				MMR				MMR			
TINE				TINE				TINE			
MEDICAL PROBLEMS				MEDICAL PROBLEMS				MEDICAL PROBLEMS			
ALLERGIES				ALLERGIES				ALLERGIES			

REGISTRATION INFORMATION				REGISTRATION INFORMATION				REGISTRATION INFORMATION			
PROGRAM	BLDG/RM	ENROLL	TERMIN	PROGRAM	BLDG/RM	ENROLL	TERMIN	PROGRAM	BLDG/RM	ENROLL	TERMIN
FULL DAY				FULL DAY				FULL DAY			
HOURLY				HOURLY				HOURLY			
PRESCH				PRESCH				PRESCH			
B/A SCH				B/A SCH				B/A SCH			
FCC HOME				FCC HOME				FCC HOME			
OTHER				OTHER				OTHER			

SPONSOR CONSENT: I ______________________ (parent)(guardian) of ______________________

give consent for an authorized CDS representative to take my child/children for care, medical or dental, in an emergency situation where 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 prior to such action and the expense, if any, will be borne by me. Treatment at an Army medical facility may be provided without additional consent under the provision of AR 40-3, paragraph 2-24b.

DATE	SIGNATURE OF SPONSOR

CHILD AND YOUTH SERVICES HEALTH ASSESSMENT / SPORTS PHYSICAL

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: Health Assessment complete sections A & C; Sports Physicals complete sections A, B & C.

PART A

Name of Sponsor	Home Telephone Cell Telephone	Duty/Work Telephone
Sponsor Unit / Work Address	Sponsor SSN	Spouse's Work Telephone

CHILD HEALTH INFORMATION

Name of Child	Birth Date	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. 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: / **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

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

YOUTH RULES OF CONDUCT

In order to have a successful program it is essential that all youth are aware of the basic rules of conduct to be followed at the Youth Service. Youth who experience a problem should remember it is important to try to resolve a conflict with words vs. violence. Staff is available to serve as a mediator should it become necessary in order to help you to find a solution. It is our goal to have a warm and friendly environment that youth can enjoy and feel safe in. Continued conflicts may result in "suspension" (designated time away) from Youth Services. Respect others, staff, peers and yourself. Use appropriate language, drugs, alcohol, smoking, guns and violence do not belong in our Centers

I have read and understand that I must follow these rules.

YOUTH NAME_____SIGNATURE_____

COMPUTER LAB AGREEMENT

The mandatory COMPUTER LAB ORIENTATION COURSE (Intro Class) is held. This class will teach your child the rules of the YS Computer Lab, including how to print from the Network printer and use the Internet.

YOUTH NAME_____SIGNATURE_____

PARENT CONSENT AND RELEASE

I hereby consent for my son/daughter participation in the Youth Services Computer Lab. I agree to waive, release and discharge the YS, its staff, and volunteers from any liabilities or injuries incurred as a result of participation by the above named child in this activity. I further agree to indemnify the YS, its staff and volunteers, against any claim made against it and/or them by any person resulting from the act and/or neglect of the above named child.

Legal Guardian's signature_____ Date _____

OBJECTION TO THE USE OF THE INTERNET

This objection applies to the current school year, and must be specifically renewed at the beginning of each school year.

I object to _____ using the Internet during the current school year.

Legal Guardian's signature_____ 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.

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. Spouse name	

8. Home phone	9. Duty phone	10. Cell phone

Part B - Identification of Child/Youth Condition/Restrictions

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

1. Allergies
   ☐ No ☐ Yes (explain)

   a. Life threatening reaction
   ☐ No ☐ Yes (explain)

   b. Epi-pen required
   ☐ No ☐ Yes

   c. Other allergic reations (hives, rash, diarrhea)
   ☐ No ☐ Yes

2. Asthma reactive airway disease
   ☐ No ☐ Yes (explain)

   a. Triggers exist for child's asthma attacks (stress, environmental, exercise)
   ☐ No ☐ Yes (explain)

   b. Child routinely (greater than 10 days per month/four months per year) uses inhaled anti-inflammatory agents and/or bronchodilators
   ☐ No ☐ Yes (explain)

   c. Child has taken steroids during the past year (prednisone, prednisolone)
   ☐ No ☐ Yes (indicate number of days in past year)

d. Child has experienced unconsciousness or seizures associated with asthma attacks
☐ No ☐ Yes (explain)

e. Child required an urgent visit to emergency room or clinic for acute asthma within the last 12 months
☐ No ☐ Yes (indicate number of visits in the past year)

f. Child has been hospitalized for asthma related condition in the past six months
☐ No ☐ Yes (explain)

3. Attention Deficit Disorder (ADD)
☐ No ☐ Yes

a. ADD with hyperactivity
☐ No ☐ Yes

b. Is not well controlled with medication
☐ No ☐ Yes (not well controlled)

c. Behavioral/conduct concerns
☐ No ☐ Yes (explain)

4. Autism
☐ No ☐ Yes

5. Behavioral/conduct concerns (for example, oppositional defiant disorder, anxiety disorder, school phobias)
☐ No ☐ Yes (explain)

6. Blindness/visual problems
☐ No ☐ Yes (explain)

7. Diabetes
☐ No ☐ Yes (explain)

8. Emotional problems that require care by a psychiatrist, psychologist or social worker
☐ No ☐ Yes (explain)

9. Epilepsy
☐ No ☐ Yes (explain)

10. Hearing problems
☐ No ☐ Yes (explain)

11. Heart problems
☐ No ☐ Yes (explain)

12. Kidney problems
☐ No ☐ Yes (explain)

13. Speech/language delay
☐ No ☐ Yes (explain)

14. Physical disability
☐ No ☐ Yes (explain)

15. Dietary restrictions
☐ No ☐ 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)

Participant: Guardian

MEMORANDUM FOR RECORD

SUBJECT: Child, Youth and School (CYS) Services 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, Youth and School (CYS) Services programs.

6. Statements of Understanding.

a. I have received the CYSS Parent Handbook and will abide by all policies.
b. I acknowledge that CYSS 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 CYSS is accurate and complete.

7. Medical Consent Statement.

a. I give consent by signing this agreement, for an authorized Child, Youth and School (CYS) Services 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