



UNITED STATES ARMY
CHILD & YOUTH SERVICES

PARENT CENTRAL SERVICES
Registration Requirements for CYS Services

- ❖ Official shot record with a Negative TB test result (12 months and older) or TB Document F: State of Hawaii TB Clearance Form, signed & stamped by a Licensed Practitioner.
- ❖ Flu shot is required for children enrolled in FULL DAY CARE. The deadline for the Flu Shot will be **December 31st** of each year. Children who are 6 months or older, or have never had the flu shot will receive the first half of the shot and then the second half 30 days later
(For more information regarding the flu shot please call (808)655-0073)
- ❖ CYS Services Health Assessment (due within 30 days of registration)
 - **If your child has special needs (i.e. asthma, diet restrictions/intolerances, seizures, ADHD, Diabetes, Autism, Eczema, Behavioral concerns, etc.) additional forms will need to be submitted. Contact one of our offices for details.**
- ❖ Two local emergency contacts (adults other than parents or legal guardian)
- ❖ Proof of Total Family Income (most recent end of month LES and/or pay stubs)
- ❖ Family Care Plan for Single/Dual Military families (due within 30 days of registration)

Parent or Guardian must attend an orientation at the program (CDC, SAC, or Youth Center) prior to utilizing child care services

Aliamanu Parent Central Services (AMR)

154 Kauhini Road, BLDG 1782

Phone (808) 833-5393

Hours 0800-1700

Walk-in 0800-1100

Appointments 1300-1600

Schofield Parent Central Services

241 Hewitt Street, BLDG 1283

Phone (808) 655-5314/ (808)655-8380

Hours 0730-1700

Walk-in 0730-1100

Appointment 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)

Unit/Employer Name: _____

Duty/Work Address: _____

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

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

SPOUSE: _____ Cell Phone #: _____
Grade Last First

Unit/Employer Name: _____

Duty/Work or College Address: _____

Include Zipcode
AKO or E-Mail Address: _____ Work/Staff Duty Phone: _____

Status: Active/Retired/DA Civilian/Civilian (circle one)

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 (other than parents or legal guardians):

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

Relationship: _____ Duty/Work Phone: _____

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

Relationship: _____ Duty/Work Phone: _____

**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	Duty/Work Telephone
	Cell Telephone	
Sponsor Unit / Work Address		Spouse's Work Telephone

CHILD HEALTH INFORMATION

Name of Child	Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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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: <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? <input type="checkbox"/> Yes <input type="checkbox"/> 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	

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

<input type="checkbox"/> Initial Registration	<input type="checkbox"/> Re-registration/already in program	Date in from Patron: _____
On waiting list? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Current Program	Date out to APHN: _____
Date care needed? _____	<input type="checkbox"/> 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
Type of Program Requested (check all that apply):			
<input type="checkbox"/> Hourly Care	<input type="checkbox"/> Full Day Care	<input type="checkbox"/> Middle School/Teen Program	<input type="checkbox"/> Summer Camp
<input type="checkbox"/> Part Day Care	<input type="checkbox"/> Before/After School Care	<input type="checkbox"/> SKIES/Instructional Classes	<input type="checkbox"/> Sports
Sponsor Name		Sponsor Email (AKO)	Sponsor SSN (Last 4 digits)
Spouse Name		Spouse Email	Sponsor DOB
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	8. Emotional problems/difficulties? <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
2. Allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No	10. Developmental Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No
a. Does it require a rescue medication? <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
3. Dietary Restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No	12. Hearing problems/difficulties? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> a. Medically-based <input type="checkbox"/> b. Religiously-based	13. Speech/language delays? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No	14. Other developmental delays? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Epilepsy/Seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No	15. Physical disability? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Attention Deficit/Hyperactivity Disorder (ADD/ADHD)? <input type="checkbox"/> Yes <input type="checkbox"/> No	16. Other medical condition or concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No
a. Is your child/youth prescribed medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain:
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	

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)

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)

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)