



UNITED STATES ARMY
CHILD & YOUTH SERVICES

PARENT CENTRAL SERVICES

Re registration Requirements for CYS Services

- ❖ Re-registration requires sponsor most current full-month LES or pay stubs, if there is a spouse, it is required for the spouse as well.
- ❖ Attached EFMP and Liability Waiver are required. Both forms are filled out by sponsor or spouse only, they do not require a doctor's signature.
- ❖ If you have turned in updated immunizations, please bring a copy with you.
- ❖ **A Sports Physical form is mandatory for participation in Youth Sports. A doctor's signature is required. Complete and return the attached Sports Physical form.**

Once you have these documents, please call or come by Parent Central Services to process your registration.

Schofield Parent Central Services

241 Hewitt Street, BLDG 1283

Phone (808)787-7464

Hours 0800-1700

Walk-in: 0800-1100 M, T, TH, F

Appointment 1200-1500

AMR Parent Central Services

154 Kauhini Rd. Bldg. 1782 Honolulu, HI 96818

Phone (808) 787-7465

Hours 1200-1600 M, T, W, TH, F

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: _____

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)

PASS SALES RECEIPT

Receipt #

Payment Date:

Participant: _____

Guardian: _____

MEMORANDUM FOR RECORD

SUBJECT: Child and Youth Services (CYS) 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 and Youth Services (CYS) programs.
6. Statements of Understanding.
 - a. I have received the CYS Parent Handbook and will abide by all policies.
 - b. I acknowledge that CYS 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 CYS is accurate and complete.
7. Medical Consent Statement.
 - a. I give consent by signing this agreement, for an authorized Child and Youth Services (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.
 - 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

This Waiver was Processed on



Child and Youth Services 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.