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)

Duty/Work Phone: __________________________

Relationship: ____

Name (2): ____ Home Phone:_____________________________

Child Release Designee: Yes/ No (circle one)

Duty/Work Phone: __________________________

Relationship: ____

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 Cell Telephone	Duty/Work Telephone
Sponsor Unit / Work Address		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. 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: ☐ Yes ☐ No

PARTICIPATION RECOMMENDATIONS

☐ All sports _____Yes _____ No ☐ Normal physical activity to including PE

☐ 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; 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**
	☐ Yes ☐ No	
Year 3 Date	**Health Status Changed**	**Signature of Parent or Guardian**
	☐ Yes ☐ 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

☐ Initial Registration
On waiting list? ☐ Yes ☐ No
Date care needed? _____

☐ Re-registration/already in program
☐ Current Program
☐ Change in Condition

Date in from Patron: _____

Date out to APHN: _____

PART A- GENERAL INFORMATION *(Parent completes)*

Child/Youth's Name	Child/Youth School Grade *(example: 3rd Grade)*	Date of Birth *(YYYYMMMDD)*	Age

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)*
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?	☐ Yes	☐ No
a. Does it require a rescue medication?	☐ Yes	☐ No
2. Allergies?	☐ Yes	☐ No
a. Does it require a rescue medication?	☐ Yes	☐ No
3. Dietary Restrictions?	☐ Yes	☐ No
☐ a. Medically-based ☐ b. Religiously-based		
4. Diabetes?	☐ Yes	☐ No
5. Epilepsy/Seizures?	☐ Yes	☐ No
6. Attention Deficit/Hyperactivity Disorder (ADD/ADHD)?	☐ Yes	☐ No
a. Is your child/youth prescribed medication?	☐ Yes	☐ No
7. Diagnosed Behavior/Conduct concerns?	☐ Yes	☐ No
a. Is your child/youth prescribed medication?	☐ Yes	☐ No
8. Emotional problems/difficulties?	☐ Yes	☐ No
9. Autism Spectrum Disorder?	☐ Yes	☐ No
10. Developmental Disability?	☐ Yes	☐ No
11. Visual problems/difficulties not corrected by glasses/ contacts?	☐ Yes	☐ No
12. Hearing problems/difficulties?	☐ Yes	☐ No
13. Speech/language delays?	☐ Yes	☐ No
14. Other developmental delays?	☐ Yes	☐ No
15. Physical disability?	☐ Yes	☐ No
16. Other medical condition or concerns? If yes, please explain:	☐ Yes	☐ 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 *(YYYYMMMDD)*

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 *(YYYYMMMDD)*

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 *(YYYYMMMDD)*	Date Returned to Parent Central Services/EFMP *(YYYYMMMDD)*

TB Document F: State of Hawaii TB Clearance Form

Hawaii State Department of Health
Tuberculosis Control Program

Patient Name	DOB	TB Screening Date

I have evaluated the individual named above using the process set out in the DOH TB Clearance Manual dated 2/10/17 and determined that the individual does not have TB disease as defined in section 11-164.2-2, Hawaii Administrative Rules.

Screening for schools, child care facilities or food handlers *(TB Document A or E)*
☐ Negative TB risk assessment
☐ Negative test for TB infection
☐ Positive test for TB infection, and negative chest X-ray

Initial Screening for health care facilities or residential care settings (*TB Document B or C)*
☐ Negative test for TB infection (2-step)
☐ New positive test for TB infection, and negative chest X-ray
☐ Previous positive test for TB infection, negative CXR within previous 12 months, and negative symptom screen
☐ Previous positive test for TB infection, and negative CXR

Annual Screening for Health care facilities or residential care settings (*TB Document D)*
☐ Negative test for TB infection
☐ New positive test for TB infection, and negative chest X-ray
☐ Previous positive test for TB infection, and negative symptoms screen
☐ Previous positive test for TB infection, and negative CXR

Signature or Unique Stamp of Practitioner: _____

Printed Name of Practitioner: _____

Healthcare Facility: _____

This TB clearance provides a reasonable assurance that the individual listed on this form was free from tuberculosis disease at the time of the exam. This form does not imply any guarantee or protection from future tuberculosis risk for the individual listed.

TB Document G: State of Hawaii TB Risk Assessment for Adults and Children

Hawaii State Department of Health
Tuberculosis Control Program

1. Check for TB symptoms

- If there are significant TB symptoms, then further testing (including a chest x-ray) is required for TB clearance.
- If significant symptoms are absent, proceed to TB Risk Factor questions.

☐ Yes ☐ No	**Does this person have significant TB symptoms?** Significant symptoms include <u>cough for 3 weeks or more</u>, plus at least one of the following: ☐ Coughing up blood ☐ Fever ☐ Night sweats ☐ Unexplained weight loss ☐ Unusual weakness ☐ Fatigue

2. Check for TB Risk Factors

- If any "Yes" box below is checked, then TB testing is required for TB clearance
- If all boxes below are checked "No", then TB clearance can be issued without testing

☐ Yes ☐ No	**Was this person born in a country with an elevated TB rate?** Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries.
☐ Yes ☐ No	**Has this person traveled to (or lived in) a country with an elevated TB rate for four weeks or longer?**
☐ Yes ☐ No	**At any time has this person been in contact with someone with *infectious TB disease*? (Do not check "Yes" if exposed only to someone with latent TB)**
☐ Yes ☐ No	**Does the individual have a health problem that affects the immune system, or is medical treatment planned that may affect the immune system?** *(Includes HIV/AIDS, organ transplant recipient, treatment with TNF-alpha antagonist, or steroid medication for a month or longer)*
☐ Yes ☐ No	**For persons under age 16 only: Is someone in the child's household from a country with an elevated TB rate?**

Provider Name with Licensure/Degree:	**Person's Name and DOB:**
Assessment Date:	**Name and Relationship of Person Providing Information (if not the above-named person):**