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
- Your current program should have your sports physical on file, please bring a copy with you
- If you have turned in updated immunizations, please bring a copy with you

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

Schofield Parent Central Services
241 Hewitt Street, BLDG 1283
Phone (808) 655-4090/ (808)787-7464
Hours 0800-1700
Walk-in 0800-1100 M, T, TH, F
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 (circle one) On Post/Off Post (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: ______________________________

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)*

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

UNITED STATES ARMY
CHILD & YOUTH SERVICES

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:

(808) 787-4109

Additional Information:

2251 McMahon Rd, Bldg 9090
Schofield Barracks, HI 96786

Parent Central Services Information:

(808) 787-7464

241 Hewitt Street, Bldg 1283
Schofield Barracks, HI 96786
Schofield: 808-787-7464

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.