UNITED STATES ARMY
CHILD & YOUTH SERVICES

PARENT CENTRAL SERVICES

Registration Requirements for CYS Services

IMMUNIZATION REQUIREMENTS
Official shot record with a Negative TB test results (12 months and older) or a TB Document F: State of Hawaii TB Clearence Form, signed & stamped by a licensed practitioner.
Flu shot is required
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) 787-5672

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 contact** (adults other that parents or legal guardian)
- **Proof of Total Family Income** (most recent end of month LES and/or paystubs for one full month
- **Family Care Plan for Single/Dual Military families** (due with 30 days of registration)
- **DA Form 7625-1** (health screening tool)

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

For electronic submission please email: **usarmy.schofield.id-pacific.mbx.cys-pcs@army.mil**

Please note: we only accept registration documents in PDF format for electronic submission or original documents submitted in person. PDF needs to be clear with nothing visible in the back-

Schofield Parent Central Services
241 Hewitt Street, BLDG 1283
Phone: (808) 787-7464 I Hours: 0800-1700
Walk-in 0800-1100 Mon, Tue, Th, Fri
Appointment 1200-1500
Wednesday by appointment only

AMR Parent Central Services
154 Kauhini Road, BLDG 1782
Phone: (808) 330-9330
Hours: Monday –Friday 0800-1400
Walk-in Only

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: ____

ARMY CHILD AND YOUTH SERVICES HEALTH SCREENING TOOL

For use of this form, see AR 608-75; the proponent agency is OTSG.

PRIVACY ACT STATEMENT

AUTHORITY:	10 U.S.C. 3013, Secretary of the Army; 29 U.S.C. 794, Nondiscrimination Under Federal Grants andPrograms; 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)

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

TB Form F: State of Hawai'i TB Clearance Form

Hawai'i 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 and determined that the individual does not have TB disease as defined in the Hawai'i Administrative Rules 11-164.2.

I. Screening for schools, child care facilities, or food handlers *(TB Document A,A.2 or E)*

☐ Negative TB risk assessment
☐ Negative test for TB infection: TST: mm, date read: ; or QFT date:
☐ Positive test for TB infection: TST: mm, date read: ; or QFT date: and negative chest X-ray (date:)

II. Initial Screening for Health Care Facilities or Residential Care Settings (*TB Document B, B.2, C, C.2)*

☐ Negative Risk Assessment: Children 1-17 yrs old, who are household members in adult residential care settings
Adults and Pediatric clients / patients living or working in a DOH licensed facility: ☐ Negative test for TB infection (2-step TST or QFT; or single TST/symptom screen plus negative CXR): TST #1: mm, date read: TST #2: mm, date read: **or** QFT date: Single TST: mm, date read: Symptoms Screen date: Negative chest X-ray date:
☐ New positive TB test: TST: mm; date read: or QFT date: Negative CXR date:
☐ Previous positive test for TB infection: ☐ negative symptoms screen, date: ☐ negative risk assessment, date: ☐ negative CXR within previous 12 months: Date of CXR:
☐ Previous positive test for TB infection, and negative CXR: Date of CXR:

III. Annual Screening for Health Care Facilities or Residential Care Settings (*TB Document D, D.2)*

☐ Negative risk assessment and negative symptom screen (Persons working in Health Care Facilities
☐ Negative test for TB infection: TST: mm, date read or QFT date:
☐ New positive test for TB infection: TST: mm, date read: or QFT date: and negative chest X-ray (date:)
☐ Previous positive test for TB infection and negative symptoms screen

Signature or Unique Stamp of Practitioner: _____
Printed Name of Practitioner (MD/DO/APRN/NP/PA): _____
Healthcare Facility: _____
Address: _____
Phone Number: _____ Fax: _____

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.

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 at by

DEPARTMENT OF THE ARMY
US ARMY INSTALLATION MANAGEMENT COMMAND
2405 GUN SHED ROAD
JOINT BASE SAN ANTONIO FORT SAM HOUSTON, TX 78234-1223

JUL 20 2020

Dear Family,

This letter is to inform you of Department of Defense changes to priorities for child care and how they may impact you. The intent of these changes is to ensure priority access to child care for military members.

The new priority system becomes effective on September 1, 2020 and applies to all new requests for child care and to children currently enrolled in full-day and regularly scheduled school-age care in military Child Development Centers, 24/7 Child Development Centers, School Age Care centers, and Family Child Care Homes.

The updated Department of Defense child care priorities are listed at the enclosure. All child care placement offers must be made through militarychildcare.com in accordance with the new priorities. Children will be placed on a wait list, according to priority, when there is not sufficient child care capacity to meet demand.

Children may be supplanted from care by children in higher priority categories whose wait times exceed 45-days beyond the date care is needed. Enclosure provides category priorities and details on patrons who may be supplanted.

Families of children who are supplanted will receive 45-day notices and may request new placements, according to their priorities, on militarychildcare.com.

Families receiving notification of supplanting may be eligible for Army Fee Assistance to help pay the cost of off-post child care and may receive enhanced referrals to help them find off-post child care. Fee assistance enrollment is in accordance with the Department of Defense priority system when there is a wait list based on funding availability. Patrons must meet eligibility requirements for Army Fee Assistance. Child and Youth Services professional are available to support and answer any questions.

Additionally, providers must meet qualification requirements and be approved. More information is available at: https://www.childcareaware.org/fee-assistancerespite/military-families/army/.

Please contact your local Child and Youth Services Program Manager for more information.

Sincerely,

Douglas M. Gabram
Lieutenant General, U.S. Army
Commanding

Enclosure

Department of Defense Priorities for Child Care

Priority 1A, CDP Staff. The children of CDP Staff are placed into care ahead of all other eligible patrons.

> CPD Staff are employees, paid from either Appropriate Funds (APF) or Non-Appropriated Funds (NAF) responsible for the care of children enrolled in CDC's and SAC's.
>
> 1A patrons may not be supplanted.

Priority 1B, in the following order of precedence: (1) Active Duty Combat-Related Wounded Warrior (2) Single or Dual Active Duty Members, (3) Single or Dual Guard and Reserve members on Active Duty, (4) Active Duty with Full-time Working Spouse, (5) Guard and Reserve on Active Duty with Full-time Working Spouse.

> Children of 1B priority patrons will be placed into care ahead of other eligible patrons, except Priority 1A patrons.
>
> Priority 1B patrons may not be supplanted.

Priority 1C, in the following order of precedence: (1) Active Duty with Part Time Working Spouse or Spouses Seeking Employment and (2) Guard and Reserve on Active Duty with Part-Time Working Spouse or Spouse Seeking Employment.

> Children of 1C priority patrons will be placed into care ahead of all other eligible patrons, with the exception of Priorities 1A and 1B.
>
> Priority 1C patrons may be supplanted by eligible patrons in Priority 1A or 1B whose anticipated placement time exceeds 45 days beyond the dates care is needed, as indicated in militarychildcare.com.

Priority 1D, in the following order of precedence: (1) Active Duty with Full-time Student Spouse and (2) Guard and Reserve members on Active Duty with Full-time Student Spouse.

> Children of 1D priority patrons will be placed into care ahead of other eligible patrons, with the exception of Priorities 1A, 1B, and 1C.
>
> Priority 1D patrons may be supplanted by eligible patrons in Priority 1A, 1B, or 1C whose anticipated placement time exceeds 45 days beyond dates care is needed, as indicated in militarychildcare.com.

Priority 2, DoD Civilians. Children of DoD civilians will be placed in the following order of precedence: (a) Single or Dual DoD Civilian/Coast guard Civilian Employees, and (b) DoD Civilian/Coast Guard Employees with Full-Time Working Spouse.

> DoD civilian patrons may only be supplanted be eligible Priority 1A or 1B patrons whose anticipated placement time exceeds 45 days beyond dates care needed as indicated in militarychildcare.com.

Priority 3, Space Available. When Priority 1 and 2 patrons are placed into care, CYS Services may place other eligible patrons not identified in Priority 1 and 2 into space available care.

Space Available patrons will be placed in the following order of precedence: (a) Active Duty with Part-Time Student or Non-Working Spouse or Guard and Reserve on Active Duty with Part-Time Student or Non-Working Spouse (b) DoD/Coast Guard Civilian with Spouse Seeking Employment, (c) DoD/Coast Guard Civilian with Full-Time Student Spouse, (d) Gold Star Spouses, (e) DoD Contractors, and (f) DoD Contractors/DoD Civilians with Part-Time or non-working spouse or Other eligible patrons.

Space available patrons may be supplanted by priority 1 or 2 patrons whose anticipated placement times exceeds 45 days beyond dates care needed as indicated in militarychildcare.com.

****

Parent Acknowledgment: I have read and acknowledge receipt of the DoD Priorities for care

Printed Name: _____ Signature: _____ Date: _____

My current priority is _____ (1A, 1B, 1C, 1D, 2, or 3- PCS staff to complete)
I understand changes to my household status must be reported to PCS within 7 days of change and may result in being assigned a different priority for care.
_____ (parent initial)

Priority 1C only (AD or Guard/Reserve on AD with Part-Time Working Spouse or Spouse Seeking Employment)
Seeking Employment Status: I understand that I have 90 days to secure employment and will notify PCS as soon as I receive a firm job offer with a date. Every 30 days, I must contact PCS with an update. On day 76, I will be issued my two week notice and vacate my space by the 90th day, if I do not secure employment.
_____ (parent initial)

90th day from today, last day of care:_____ 76th day submit two week notice:_____

Part-Time Employment:
I understand that I must update PCS within 7 days in the event my employment changes from part-time to full-time. Full-time is defined as 30 hours per week or more on a regular basis.
_____ (parent initial)

Priority 1D only (AD w/FT Student Spouse or Guard/Reserve on Active Duty w/FT Student Spouse)
I understand that I must submit my school schedule every 90 days or sooner based on school term. Failure to submit will result in care being suspended, fees assessed at a CAT 11 rate (child care fees apply during suspensions) and my priority changing to Priority 3 (Space available).
_____ (Parent signature)

Update 1 Due: _____/ Initial _____ Update 2 Due: _____/ Initial _____

Update 3 Due: _____/ Initial _____ Update 4 Due: _____/ Initial _____

Encl