CYS Registration Checklist

CDC / SAC / Hourly Care

- ☐ CYS Registration Form
- ☑ CYS Services Health Screening Tool
- ☐ CYS Health Assessment/Sports Physical
- ☐ Copy of Immunizations Records for infants to Preschool-aged children and homeschool/off-post schools
- ☐ Medical Action Plans Forms if child(ren) have Dietary Restrictions, Allergies, Respiratory Issues or other health concerns
- ☐ PCS / Travel Orders / Command Sponsored / Pin point Orders / Letter of Employment (LOE)
- ☐ Family Care Plan DA Form 5305-R Single / Dual Military Only
- ☐ When CDC/SAC Care is offered from Parent Central: Copy of most recent Leave and Earning Statement (LES) from each parent / LQA (not required for Hourly Care)

Sports / SKIES

- ☐ CYS SKIES and Youth Sports and Fitness Registration Form
- ☑ CYS Health Screening Tool
- ☐ CYS Health Assessment/Sports Physical
- ☐ SKIES*Unlimited* Statement of Understanding
- ☐ Copy of Immunizations Records for infants to Preschool-aged children and homeschool/off-post schools
- ☐ Medical Action Plans (MAPs) if child(ren) have dietary restrictions, allergies, respiratory issues or other health issues/concerns

Middle School Teen (MST) Center

- ☐ CYS Teen Registration Form/Sponsor Consent
- ☐ MST Standard of Conduct/SOPs
- ☐ Youth Technology Lab (YTL) Parent Permission Agreement
- ☐ 4-H Youth Development Program (Optional)
- ☐ Parent Orientation Checklist
- ☐ Medical Action Plans (MAPs) if child(ren) have dietary restrictions, allergies, respiratory issues or other health issues/concerns

If the child has any medical issues/concerns the Health Screening Tool and Health Assessment/Sports Physical has to be provided as well

Parent Central requests that you please have all paperwork complete PRIOR to your registration appointment and bring all required documents with you at the time of your appointment.
If you are unable to provide all the needed information or need additional time to get all the necessary paperwork, we ask that you please re-scheduled for a later appointment date.
To make/cancel an appointment, or for questions/concerns stop by Parent Central, BLDG 6400 or call us at DSN: 757-2250/2254/2255.

To help cut down appointment times, you may visit Army WebTrac to input your information at the URL below:
https://webtrac.mwr.army.mil/

UNITED STATES ARMY
CHILD & YOUTH SERVICES

U.S. ARMY MWR
SOLDIERS · FAMILIES · RETIREES · CIVILIANS

USAG Humphreys Parent Central BLDG 6400

Hours of Operation: MON, WED, FRI 0800-1700
TUE 0800-1900
THUR 1200-1700
Contact Number: DSN 757-2250/2254/2255
Commercial: 0503-357-2250/2254/2255
APPOINTMENTS ARE REQUIRED FOR REGISTERING

CDC & SAC Registration

CHILD'S NAME (Last, First)	ETHNICITY	RELATION	AGE	DOB (MMDDYY)	CURRENT GRADE

	Rank	DSN
APO Mailing Address	Photo Release (Yes/No)	DEROS (MMDDYY)
Home Address		
Sponsor's Full Name	Spouse's Full Name	
Sponsor's Cell Phone #	Spouse's Cell Phone #	
Sponsor Work Email	Spouse Email	

(Emergency contacts cannot be the Sponsor and Spouse)

Emergency Contact/ **Release #1**	Cell #
Emergency Contact/ **Release #2**	Cell #

Required Documents that must be COMPLETELY filled out prior to your SCHEDULED appointment

✔	1	**Army Child and Youth Services Health Screening Tool**
	2	**Health Assessment (30 days granted for child/youth with no special needs annotated on DA Form 7725)**
	3	**PCS / Travel Orders /Command Sponsored / Pin point Orders / Letter of Employment (LOE)**
	4	**Copy of Immunization Records (Required if child is CDC age or do not attend Humphreys School)**
		(PPD waiver/ TB Skin test required above 5 years old)
	5	**MIAT forms required if child has Respiratory, Special diet, Allergies or other health issues.**
		☺ **Copy of most recent LES/ Pay Stub from each parent when the request for care on MCC has been approved by Parent Central**
		Dual/Single Military Only
	7	**Family Care Plan (DA Form 5305-R) Single /Dual Military Only (Completed with-in 30 days of enrollment or services denied)**

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	

ARMY CHILD AND YOUTH SERVICES HEALTH SCREENING – TOOL #1

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 3013, Secretary of the Army; 29 U.S.C. 794, Nondiscrimination Under Federal Grants and Programs, DoDD 1342.17 Family Policy; AR 608-75, Exceptional Family Member Program: AR 608-10, Child Development Services; and E.O. 9397 (SSN).

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.

SNAP Case Number: _____

FOR CER COMPLETION ONLY

□ Initial Registration
Is child on waiting list? □ Yes □ No
Date care needed? _____
□ Re-registration/Child Already in Program
□ Change in Program

Date in from Patron:

Date out to APHN:

Part A – General Information

Child/Youth Name	Child/Youth School Grade (example: 3rd Grade)	Date of Birth (YYYYMMDD)	Age

Type of Placement Requested: (check all that apply)

□ Hourly Care □ Full Day Care □ Middle School/Teen Program □ Summer Camp □ Other: (specify)
□ Part Day Care □ Before/After School Care □ SKIES/Instructional Classes □ Sports

Sponsor Name	Sponsor E-mail	Best Contact Number

Spouse Name	Spouse E-mail

Home Phone	Cell Phone	Sponsor Unit

Home Address	Sponsor Duty Phone

Part B – Identification of Child/Youth Condition/Restrictions

Does you child have any of the following conditions/restrictions: (check no or yes and answer questions as appropriate)

1. Allergies
   a. Life threatening reaction? □ No □ Yes
   b. Rescue Medication (Epi-pen, Benadryl, Inhaler) □ No □ Yes
   c. Does child/youth need rescue inhaler? □ No □ Yes
   If your child/youth has an allergy, please list: _____
   _____
   Reaction: _____
   _____
2. Special Diet □ No □ Yes
   a. Is your child on a complex diet (i.e. gluten free, diabetic) □ No □ Yes
   b. Does your child have a food intolerance/mild food allergy (i.e. rash from strawberries/milk intolerance)? □ No □ Yes
   c. Does your child have a dietary religious restriction? □ No □ Yes
3. Asthma/Reactive Airway Disease/Breathing Problems? □ No □ Yes
   a. Does your child need a rescue med? □ No □ Yes
4. Does your child have diabetes? □ No □ Yes
5. Does your child have seizures? □ No □ Yes
6. Attention Deficit Disorder (ADD/ADHD)
   a. Are there behavior/conduct concerns while on meds? □ No □ Yes
   b. List ADD/ADHD medications: _____
   _____
   _____
   _____
7. Behavior/ conduct concerns (oppositional defiant disorder, anxiety, depression, bipolar, other)? □ No □ Yes
8. Autism Spectrum Disorders (Autism, Aspergers, Rett Syndrome, PDD-NOS) □ No □ Yes
9. Does your child have any of the following health concerns? (circle all that apply)- Hearing impairment, vision impairment other than corrective lenses, heart, kidney, physical disability SEVERE skin condition □ No □ Yes
   Please specify _____
   _____
10. Does your child have a speech/language and/or hearing loss that affects their ability to communicate their basic needs (hurt, bathroom, fear, thirst)? □ No □ Yes
    Explain: _____
    _____
    _____
11. Does your child have developmental delays other than MILD speech language/MILD hearing loss? □ No □ Yes
    Explain: _____
    _____
12. Are there any other conditions or concerns that you would Like staff to be aware of? □ No □ Yes
    Explain: _____

Part C – Medications

List any medications that are prescribed for your child/youth other than those listed above:

Will your child require medication administration during child care/youth supervision hours? □ No □ Yes

Part D – Early Intervention and Special Education

Does your child/youth receive special services/therapies? □ No □ Yes
Please specify: _____

Does your child/youth have an Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP) or 504 Plan? □ No □ Yes

Part E – Exceptional Family Member Program (EFMP) Enrollment

Is your child enrolled in the EFMP? □ No □ Yes If yes, specify for what condition: _____

_____ _____
Printed Name and Signature of Parent/Personal Representative of Child/Youth Date (YYYYMMDD)

If you have answered NO to all the questions above you are now finished with this form.
Please sign and date indicating that the information above is accurate and complete to the best of your knowledge.

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 please notify CYS Services immediately.

If you answered YES to any of the questions above, complete Part F on the next page.

Child/Youth Name	Date of birth (YYYYMMDD)	Age

Part F – Release of Information

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 SNAP 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 and Signature of Parent/Personal Representative of Child | Date (YYYYMMDD)

Part G – Army Public Health Nurse (APHN) Review

Current Medications other than those listed on page 1:

Diagnosis: _____

Background/Notes:

Medical Records Reviewed? □ No □ Yes □ Not Available

Training for CYS Staff/Provider Required:

Recommendation Summary:

SNAP REQUIRED: □ No SNAP required □ Modified □ Full □ Annual Review (No team meeting required)

Requirements Prior to Placement:

Medical Action Plan reviewed by APHN: □ Respiratory □ Allergy □ Seizure □ Diabetes □ Special Diet □ Other_____

APHN Printed Name or Stamp	APHN Signature	Date (YYYYMMDD)

Date Received by APHN	Date Returned to CER:

Form Updated: 11 Mar 09

SPECIAL NEEDS ACCOMMODATION PROCESS (SNAP) ACTION PLAN – TOOL #2

(copy to be kept in child/youth's care module)

Child's Name	Date of Birth (YYYYMMDD)	Date of SNAP

Diagnosis:	Date of Annual Review:

Approved for the following CYS Program: □ All CYS Programs/services □ CDC □ FCC □ SAS

□ Middle School/Teen □ Sports □ SKIES/instructional classes

□ Other:_____

Approved for the following CYS Service: □ Hourly □ Part Day □ Full Day

RECOMMENDATION

□ IEP goals/interventions □ IFSP goals/interventions □ Copy of 504 goals/interventions
□ Copy of Behavioral Assessment/Plan
□ Copy of MAP Type: _____ Other:_____

Medications: (only list medications to be administered while child is at the CYS program site)

Activity Restrictions/Adaptive Equipment, etc:

Training for CYS Staff/Provider Required:

Recommendation Summary:

I concur with this plan as outlined above.

_____ _____
Printed Name & Signature of EFMP Manager, Chair SNAP Team Date (YYYYMMDD

_____ _____
Printed Name & Signature of Child/Youth Services Coordinator/Designee Date (YYYYMMDD)

_____ _____
Printed Name & Signature of Army Public Health Nurse Date (YYYYMMDD)

_____ _ _____
Printed Name & Signature of Parent Date (YYYYMMDD)

Form Updated: 11 Mar 09