**Office Use Only
Start Date \_\_\_\_\_\_\_\_\_\_\_\_
Instructor \_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE PRINT**

Youth Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
( ) Check here if last name is different than sponsor
Age \_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender ( M / F ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Physical / Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Military Sponsor’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duty Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Unit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Rank \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Person to notify in case of emergency:**
Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I would like to enroll in:
CLASS TIME COST
1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
I allow my child to be photographed and/or videotaped (circle one): YES / NO
DOES THE YOUTH HAVE ANY DISABILTIY THAT THE INSTRUCTOR / COACH SHOULD BE AWARE OF? If so, please describe:
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Fees must be paid in full by the 25th of the previous month. If payment is not received by this day, your child will be dis-enrolled from the class and not allowed to participate until payment has been received.** Refunds will not be given unless deploying or PCSing and orders must be provided to Parent Central Services (PCS). Cancellations must be made at least two weeks in advance.

**Release & Hold Harmless**
I hereby release the USAG-Humphreys Child, Youth and School Services and the United States Government from any liabilities or claims arising from my child’s participation in a SKIES*Unlimited* program. I agree to release, waive, indemnify, promise not to sue, hold harmless the U.S. Army, its agents, employees, for any loss, damage, or injury to my person or property that may occur as a result of taking part in this activity. I also agree that I may be held liable for any damage or loss to government property that is caused by negligence, willful misconduct or fraud.
I understand that if my child is enrolled in the CDC or SAC programs, it is my responsibility to ensure that my child is signed in / out and transported to and from SKIES classes.

I, parent / legal guardian of the above child, consent to his / her taking part in this activity.
Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **ARMY CHILD AND YOUTH SERVICES HEALTH SCREENING TOOL**For use of this form, see AR 608-75; the proponent agency is OACSIM. |
| **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; AE 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 |
| 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 reactions (hives, rash, diarrhea) [ ] No [ ] Yes  |
| 2. Asthma reactive airway disease [ ] No [ ] Yes (explain) |
| * 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 (explain) |
|  b. Is not well controlled with medication [ ] No [ ] Yes (not well controlled) |
|  c. Behavioral / conduct concerns [ ] No [ ] Yes (explain) |
| 4. Autism [ ] No [ ] Yes (explain) |
| 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 Services Plan (ISFP), 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 and Youth Services (CYS)/Special Needs Accommodation Process (SNAP) personnel and their staff that is necessary to construct SNAP review. This authorization will remain in effect for one year. I understand that 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 the 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 TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRCARE Health Plan benefits on failure to obtain this authorization.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Parent or Personal Representative of Child Date (YYYYMMDD) |