



# CYS Registration Checklist



If requesting childcare (Full Day, Part Day, or Before/After Kinder-5<sup>th</sup> Grade) at CDC or SAC, you must submit your request(s) for care through <https://militarychildcare.com/>. All offers will be sent through the Military Child Care website based on new 01SEP20 priorities and availability.

**Verification of employment status will be required.**

## CDC/SAC/Hourly Care

- CYS Registration Form (needed annually to verify information)
- Space Priorities Memo (needed at initial registration)
- CYS Health Screening Tool (needed annually)
- CYS Health Assessment (may be signed up to 3 years for childcare if no changes to medical condition – a new Health Assessment is required if there are any changes to or removal of any medical conditions)
- Copy of immunizations records for children that do not attend DODEA School (i.e., not in school, home school/private school)
- **Medical Action Plan Forms\*** if child has any of the following documented medical conditions: dietary restrictions, allergies (food or medication), respiratory issues, or other health concerns (needed annually)
- PCS / Travel Orders / Command Sponsored / Pin point Orders / Letter of Employment (LOE)
- Family Care Plan DA Form 5305-R for Single/Dual Military Only (needed annually)
- Once offer for care is given by Military Child Care website/CYS staff, the following will be requested: Copy of most recent Leave and Earning Statement (LES) from each working parent or proof of employment with salary / LQA to calculate annual Total Family Income (needed annually – not required for hourly care)

## Sports/SKIES

- CYS Registration Form (needed annually to verify information)
- CYS Health Screening Tool (needed annually)
- Copy of immunizations records for children that do not attend DODEA School (i.e., not in school, home school/private school)
- FOR SKIES ONLY: CYS Health Assessment (may be signed up to 3 years for SKIES if no changes to medical condition – a new Health Assessment is required if there are any changes to or removal of any medical conditions)
- FOR SPORTS ONLY: CYS Sports Physical (needed annually as indicated on the form)
- **Medical Action Plan Forms\*** if child has any of the following documented medical conditions: dietary restrictions, allergies (food or medication), respiratory issues, or other health concerns (needed annually)
- FOR SKIES ONLY: SKIESUnlimited Statement of Understanding (needed annually)
- FOR SPORTS ONLY: Parents' Code of Ethics (needed annually)

## Middle School – Teen (MST) Youth Center

- CYS Youth Program Registration & Sponsor Consent Form (IMCOM FORM 34, JUN 2019) – (may be signed up to 4 years if no changes to information)
- Youth Center Packet: Parent Orientation Checklist / Standard of Conduct / Facility specific forms (needed at initial registration)
- Copy of immunizations records for children that do not attend DODEA School (i.e., not in school, home school/private school)
- The below documents are needed annually if youth has any of the following documented medical conditions: dietary restrictions, allergies (food or medication), respiratory issues, or other health concerns:
  - CYS Health Assessment (may be signed up to 3 years for Youth Center services if no changes to medical condition – a new Health Assessment is required if there are any changes to or removal of any medical conditions)
  - CYS Health Screening Tool
  - **Medical Action Plan Forms\***

**\*Medical Action Plan Forms:** Please contact Parent Central Services by email if you are unsure of which forms are needed for your child/youth's registration. Forms include: Allergy Medical Action Plan, Respiratory Medical Action Plan, Diabetes Medical Action Plan, Seizure Medical Action Plan, and Special Dietary Statement.

All documents and information must be complete to process your registration (new/renewal). If attending an in-person registration appointment, all documents and information must be complete and brought to your appointment with Parent Central Services. If you are unable to provide the necessary information/documents or need additional time, you may be asked to re-schedule your appointment for a later date/time.

Please contact Parent Central Services by email, or call/stop by our office (BLDG 6400) to make/cancel an appointment or for general questions/concerns. Registrations may be completed electronically by email or on WebTrac if all information and documents are provided.



# USAG Humphreys CY S Registration Form



Sponsor (Senior Member by years of service if DUAL)		Spouse		FOR PARENT CENTRAL USE ONLY
Full Name:	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<b>For CDC/SAC:</b> <input type="checkbox"/> Sponsor LES/LOE <input type="checkbox"/> Spouse LES/LOE <input type="checkbox"/> TFI complete <input type="checkbox"/> FCP <input type="checkbox"/> Student/Seeking: • 30: _____ • 60: _____ • 90: _____  <b>Renewals</b> <input type="checkbox"/> Cancel old registration pass if renewing prior to expiration  <b>Memos:</b> <input type="checkbox"/> Priorities Memo <input type="checkbox"/> Space Available Memo <input type="checkbox"/> Initial Reg Memo <input type="checkbox"/> Verification Memo <input type="checkbox"/> ETP Request  <b>Childcare Offer:</b> <input type="checkbox"/> Orientation Invite <input type="checkbox"/> CYMS Activity Enrollment <input type="checkbox"/> 10% or full paid  <b>Special Notes/Reminders:</b>    Admin/Date:  Management/Date:
Unit / Employer / School Institution:				
Status:	CYS employee / Combat Related Wounded Warrior / Active Duty / Coast Guard / DoD Civilian / Other Federal / Eligible Contractor / Reservist / Retiree / Student / Seeking employment / unemployed not seeking / Other:			
Select One:	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Flex	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Flex		
Branch / CYS program (if CYS employee):	Army / Air Force / Marines / Navy / Coast Guard / CDC / SAC / MST / YSF / OS / Other:			
Rank / Position (if CYS employee):				
Work number:				
Work Email:				
Local Cell Number:				
Personal Email:				
Mailing Address :				
Physical Address (or Housing / Apt Complex Name):				



# USAG Humphreys CY S Registration Form



2 Local Emergency Contacts (must have base access):	Contact # 1: Full Name / Cell Phone Number	Contact # 2: Full Name / Cell Phone Number	Special Notes/ Reminder:

Child Information (Oldest to Youngest)								FOR PARENT CENTRAL USE ONLY (Upload to CYMS and Input Dates)											
Full Name:	M/F	Age	DOB MM/DD/YYYY	Current Grade	School	Ethnicity	Photo Release Y/N	HA	HST	Shots	MST	PCOE	SKIES	AMAP	SDS	RMAP	Waiver (Cancel OLD pass)	Other	
	<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

# 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	Duty/Work Telephone
	Cell Telephone	
Sponsor Unit / Work Address		Spouse's Work Telephone

### CHILD HEALTH INFORMATION

Name of Child	Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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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

<b>PART B: Physical Exam</b>				
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	
	<b>NORMAL</b>	<b>ABNORMAL</b>	<b>N / A</b>	<b>COMMENTS</b>
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: <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>PARTICIPATION RECOMMENDATIONS</b>				
<input type="checkbox"/> All sports _____Yes_____No		<input type="checkbox"/> Normal physical activity to including PE		
<input type="checkbox"/> Additional comments:		<input type="checkbox"/> Restrictions:		

Sports Physical is valid for 1 year from date indicated below

<b>PART C</b>		
<b>Special Medical Considerations:</b> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Date</b>	<b>Licensed Health Care Professional Stamp</b>	<b>Licensed Health Care Professional; Dr., NP or PA Signature</b>
<b>Initial Date</b>	<b>Type or print name of Parent or Guardian</b>	<b>Signature of Parent or Guardian</b>

**HASPS Renewal (Not Part of the Sports Physical)**

Year 2 Date	Health Status Changed	Signature of Parent or Guardian
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Year 3 Date	Health Status Changed	Signature of Parent or Guardian
	<input type="checkbox"/> Yes <input type="checkbox"/> 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: \_\_\_\_\_

**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**

<input type="checkbox"/> Initial Registration	<input type="checkbox"/> Re-registration/already in program	Date in from Patron: _____
On waiting list? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Current Program	Date out to APHN: _____
Date care needed? _____	<input type="checkbox"/> Change in Condition	

**PART A - GENERAL INFORMATION (Parent completes)**

Child/Youth's Name	Child/Youth School Grade (example: 3rd Grade)	Date of Birth (YYYYMMDD)	Age
Type of Program Requested (check all that apply):			
<input type="checkbox"/> Hourly Care	<input type="checkbox"/> Full Day Care	<input type="checkbox"/> Middle School/Teen Program	<input type="checkbox"/> Summer Camp
<input type="checkbox"/> Part Day Care	<input type="checkbox"/> Before/After School Care	<input type="checkbox"/> SKIES/Instructional Classes	<input type="checkbox"/> Sports
Sponsor Name		Sponsor Email (AKO)	
Spouse Name		Spouse Email	
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? a. Does it require a rescue medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	8. Emotional problems/difficulties?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Allergies? a. Does it require a rescue medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	9. Autism Spectrum Disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Dietary Restrictions? a. Medically-based <input type="checkbox"/> b. Religiously-based	<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Developmental Disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Visual problems/difficulties not corrected by glasses/contacts?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Epilepsy/Seizures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Hearing problems/difficulties?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Attention Deficit/Hyperactivity Disorder (ADD/ADHD)? a. Is your child/youth prescribed medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	13. Speech/language delays?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Diagnosed Behavior/Conduct concerns? a. Is your child/youth prescribed medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	14. Other developmental delays?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		15. Physical disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		16. Other medical condition or concerns? If yes, please explain:	<input type="checkbox"/> Yes <input type="checkbox"/> 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 (YYYYMMDD)
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**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 (YYYYMMDD)
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**Statement of Understanding**  
**SKIESUnlimited Instructional Programs**

**Enrollment & Fees:**

Fees for the following month's lessons must be paid in full by the 25<sup>th</sup> of the current month. If payment is not received by the 25<sup>th</sup>, your child's space in class will be lost if there is a wait list. You may request to be added to the bottom of the wait list if this occurs.

**Refunds:**

Refunds will not be authorized unless a family is PCSing, deploying, or the student is unable to participate in classes due to medical illness or injury. Documentation will be required to be provided to Parent Central Services (PCS).

**Supervision:**

All children & youth under the age of 10 years, must be accompanied by a parent or legal guardian during SKIES Instructional classes. Accompanying guardians will be expected to wait in the Parent Waiting Area while student is receiving instruction. If siblings or other guests are present, they will be expected to also sit in the waiting area and behave in a manner so as not to disrupt classes.

**Food & Drinks:**

Due to the fact that there are students with severe allergies and dietary restrictions, food and drinks are not allowed in the classroom, with the exception of water.

**SKIES Class Information:**

Please ask a Parent Central staff for the SKIES class brochure for specific information about the program that you are interested in.

**Class Cancellations:**

Please check for class cancellations on our USAG Humphreys CYS Facebook page. Also, please remember to read the "Special Comments" section to also check for projected class cancellations.

**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 SKIESUnlimited program. I agree to release, waive, indemnify, promise not to sue, hold harmless the U.S. Army, its agents and 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.

My signature below certifies that I have read, understand, and agree to abide by the above SKIES Unlimited Instructional Program's policies and expectations.

\_\_\_\_\_  
**(Printed Name)**

\_\_\_\_\_  
**(Signature)**

\_\_\_\_\_  
**(Date)**





# Parents' Code of Ethics



*I hereby pledge to provide positive support, care, and encouragement for my child participating in youth sports by following this PAYS Parents' Code of Ethics:*

I will encourage good sportsmanship by demonstrating positive support for all players, coaches, and officials at every game, practice, or other youth sports event.

I will place the emotional and physical well-being of my child ahead of a personal desire to win.

I will insist that my child play in a safe and healthy environment.

I will require that my child's coach be trained in the responsibilities of being a youth sports coach and that the coach upholds the Coaches' Code of Ethics.

I will support coaches and officials working with my child, in order to encourage a positive and enjoyable experience for all.

I will demand a sports environment for my child that is free from drugs, tobacco, and alcohol, and will refrain from their use at all youth sports events.

I will remember that the game is for youth - not for adults.

I will do my very best to make youth sports fun for my child.

I will help my child enjoy the youth sports experience by doing whatever I can, such as being a respectful fan, assisting with coaching, or providing transportation.

I will ask my child to treat other players, coaches, fans, and officials with respect regardless of race, sex, creed, or ability.

I will read the National Standards for Youth Sports and do what I can to help all youth sports organizations implement and enforce them.

\_\_\_\_\_  
Sponsor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse Signature

\_\_\_\_\_  
Date



Sponsor's Name: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

SUBJECT: Child, Youth & Services Space Priorities Memo

**1. You are identifying your family priority as (CHOOSE ONE):**

X	Military Family Type	Priority
<b>Child Development Program Staff</b>		
	Child Development Program Staff	1A
<b>Active Duty Combat Related Wounded Warrior</b>		
	Combat Related Wounded Warrior	1B.2
<b>Active Duty Military/Active Duty Coast Guard</b>		
	Single/Dual Active Duty Military/ Coast Guard	1B.2
	With Full-Time Working Spouse	1B.4
	With Part-Time Working Spouse	1C.1
	With Spouse Seeking Employment	1C.1
	With Full-Time Student Spouse	1D.1
	With Non-Working Spouse	3A
<b>Guard/Reserve on Active Duty or Inactive Duty Training Status</b>		
	Single/Dual Guard/Reserve on Active Duty or Inactive Duty Training Status	1B.3
	With Full-Time Working Spouse	1B.5
	With Part-Time Working Spouse	1C.2
	With Spouse Seeking Employment	1C.2
	With Full-Time Student Spouse	1D.2
	With Non-Working Spouse	3A

X	Military Family Type	Priority
<b>DOD/Coast Guard Civilian</b>		
	Single/Dual DoD or Coast Guard Civilian	2A
	With Full-Time Working Spouse	2B
	With Part-Time Working Spouse	3B
	With Spouse Seeking Employment	3C
	With Full-Time Student Spouse	3F
	With Non-Working Spouse	3F
<b>Gold Star Spouse (Combat Related)</b>		
	Gold Star Spouse (Combat Related)	3D
<b>DOD Contractor</b>		
	Single/Dual DoD Contractor	3E
	With Full-Time Student Spouse	3E
	With Spouse Seeking Employment	3E
	With Full-Time Student Spouse	3E
	With Part-Time Working Spouse	3F
	With Non-Working Spouse	3F
<b>Other Eligible</b>		
	Deactivated Guard/Reserve Personnel	3F
	Other Federal Employees	3F
	Military Retirees	3F

**2. Supplanting Notification**

In accordance with the Department of Defense Instruction 6060.02 incorporating Change 2, effective September 1, 2020, at the time of enrollment, CDPs must notify patrons in Priority 1C and lower, in writing, that they may be supplanted if a patron in a higher priority requires child care. The CDP must also provide notice of discontinued child care to patrons affected a minimum of 45 days before child care termination. \_\_\_\_\_ (Sponsor's and Spouse's Initials)

**3. Spouse Status: Seeking Employment**

Spouses actively seeking employment must submit verification every 30 days once the child is enrolled in care. The child may be removed from care if the spouse has not gained employment after 90 days. The installation commander may authorize an extension of care beyond 90 days as long as higher priority patrons are not impacted. Requests for extensions must be submitted at the 60 days verification to allow time for proper routing and review. Verification of seeking employment must be verified every 30 days. If verification day falls on a non-business day, verification must be provided by the previous business day. Care will not exceed 90 days unless otherwise approved. \_\_\_\_\_ (Spouse's Initials as applicable)



**4. Spouse Status: Enrolled in a post-secondary institution on a full-time basis**

Spouses enrolled in a post-secondary educational program on a full time basis must verify educational admission or enrollment as a full time student every 90 days once the patron is enrolled in care. If, at the time of verification, the spouse is not currently enrolled, they must show proof of resumption of full time student status within 30 days or the child may be removed from care. If verification day falls on a non-business day, verification must be provided by the previous business day. \_\_\_\_\_ (Spouse's Initials as applicable)

**5. Verification will be due every 30 or 90 days based on identified priority (as applicable):**

**30 Days:** \_\_\_\_\_ **60 Days:** \_\_\_\_\_ **90 Days:** \_\_\_\_\_

**Sponsor's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Spouse's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent Central Services Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

ENCLOSURE 3

PROCEDURES

1. CHILD CARE REQUEST AND WAITLIST MANAGEMENT

a. Request for Care. Families will apply for and request child care through MilitaryChildCare.com (MCC) for all military-operated child care.

b. Waitlist Management. Installation CDPs will utilize MCC as the method to manage child care spaces, active care options, and offerings.

c. Declining Care. In the event that a family declines care at an installation where they have requested care through MCC, they will be removed from all current waitlists and must re-request care through MCC.

2. PRIORITY SYSTEM. Priority for care is administered by MCC based on the eligibility requirements defined in paragraph 4.d. of the front matter of this instruction. Individual priority is verified at the time of enrollment and annually thereafter.

a. Priority 1. CDP Direct Care Staff, Service Members. The children of CDP Direct Care Staff and Service members will be placed into care utilizing the following guidance:

(1) Priority 1A. CDP Direct Care Staff. The children of Direct Care CDP staff will be placed into care ahead of all other eligible patrons. At no time will the child of a Direct Care CDP staff member be removed from the program to accommodate another eligible patron.

(2) Priority 1B. Single or Dual Active Duty Members; Single or Dual Guard or Reserve Members on Active Duty or Inactive Duty Training Status; and Service Members With a Full-time Working Spouse. The children of patrons that fall under Priority 1B will be placed into care ahead of all other eligible patrons except Priority 1A. At no time will a Priority 1B patron be removed from the program to accommodate any other patron, including 1A patrons. The following order of precedence will be utilized:

(a) Single or Dual Active Duty members.

(b) Single or Dual Guard or Reserve Members on Active Duty or Inactive Duty training status.

(c) Active Duty with a full-time working spouse.

(d) Guard or Reserve Members on Active Duty or Inactive Duty training status with a full-time working spouse.

(3) Priority 1C. Active Duty Members or Guard or Reserve Members on Active Duty or Inactive Duty Training Status with Part-Time Working Spouse or a Spouse Seeking Employment. The children of patrons that fall under Priority 1C will be placed into care ahead of all other eligible patrons except for Priority 1A and 1B patrons. Priority 1C patrons may only be supplanted by an eligible patron in Priority 1A or 1B when the Anticipated Placement Time of the Priority 1A and 1B patron exceeds 45 days beyond their Date Care Needed (as indicated in MCC). The following order of precedence will be utilized:

(a) Active Duty members with a part-time working spouse or a spouse seeking employment.

(b) Guard or Reserve Members on Active Duty or Inactive Duty training status with a part-time working spouse or a spouse seeking employment.

(4) Priority 1D. Active Duty Members or Guard or Reserve Members on Active Duty or Inactive Duty Training Status with a Spouse Enrolled in a Post-Secondary Institution on a Full-Time Basis. The children of patrons that fall under Priority 1D will be placed into care ahead of all other eligible patrons except for Priority 1A, 1B, and 1C patrons. Priority 1D patrons will be supplanted by an eligible patron in Priority 1A, 1B, or 1C when the Anticipated Placement Time of the Priority 1A, 1B, and 1C patron exceeds 45 days beyond their Date Care Needed (as indicated in MCC). The following order of precedence will be utilized:

(a) Active Duty members with a spouse enrolled in a post-secondary institution on a full-time basis.

(b) Guard or Reserve Members on Active Duty or Inactive Duty training status with a spouse enrolled in a post-secondary institution on a full-time basis.

b. Priority 2. DoD Civilians. The children of DoD civilians will be placed into care utilizing the following guidance:

(1) Patrons in Priority 2 will utilize the following order of precedence for placement:

(a) Single or dual DoD Civilian Employees.

(b) DoD Civilian Employees with a full-time working spouse.

(2) DoD civilian patrons may only be supplanted from care by an eligible Priority 1A or 1B patron when the Anticipated Placement Time of the Priority 1A or 1B patron exceeds 45 days beyond their Date Care Needed (as indicated in MCC).

c. Priority 3. Space Available. When all Priority 1 and 2 patrons have been placed into care, CDPs may place additional eligible patrons not identified in Priority 1 and 2 into Space Available care.

(1) Space Available patrons will be supplanted, within 45 days' written notice, by an eligible Priority 1 or a Priority 2 patron when the Anticipated Placement Time of the Priority 1 or a Priority 2 patron exceeds 45 days beyond their Date Care Needed (as indicated in MCC).

(2) The following order of precedence will be followed when placing eligible patrons into Space Available.

- (a) Active Duty with non-working spouse.
- (b) DoD Civilian Employees with spouse seeking employment.
- (c) DoD Civilian Employees with a spouse enrolled in a post-secondary educational program on a full time basis.
- (d) Gold Star spouses.
- (e) DoD contractors.
- (g) Other eligible patrons.

3. PRIORITY DETERMINATION. The following factors will be applied when making priority determinations for eligible patrons.

a. Deactivated Guard or Reserve Members. When a currently enrolled Guard or Reserve member is no longer in an Active Duty status, they must inform the appropriate CDP. The CDP will make a new priority determination for possible continued enrollment. If the member falls to a lower priority category and the child care space is needed for a higher priority patron, the Guard or Reserve member will be given 45 days' written notice regarding their removal from the program.

b. U.S. Coast Guard. For the purpose of this instruction, Coast Guard Service members (Active Duty and Reserve Component) and civilian employees will hold the same priority as equivalent DoD Service members and civilian employees, as detailed above, regardless of the Department in which the Coast Guard is operating.

c. Combat-Related Wounded Warriors in an Active Duty Status. When Service members designated as combat-related wounded warrior in an Active Duty status requires hospitalization, extensive rehabilitation, or significant care from a spouse or care provider and requires full-time child care, they may be placed into Priority 1B. This designation requires installation commander approval (this authority cannot be delegated).

d. Exceptions. Exceptions to the priority system described in this enclosure will only be authorized, in writing, for unique mission-related requirements. Authority for these exceptions lies with the installation commander responsible for the management of the CDP at the installation level.

4. VERIFICATION REQUIREMENTS. The following methods will be utilized to determine eligibility:

a. A working spouse must provide verification of employment such as a Pay/Leave and Earning Statement, Form 1099-MISC, Schedule C (Form 1040 or 1040 SR), or a self-certification statement with an estimated number of hours worked on a weekly or monthly basis. In the event that specific employment situations are not sufficiently documented by these forms, an exception to policy may be granted at the installation commander level.

b. Spouses actively seeking employment must submit verification every 30 days once the child is enrolled in care. The child may be removed from care if the spouse has not gained employment after 90 days. The installation commander may authorize an extension of care beyond 90 days as long as higher priority patrons are not impacted.

c. Spouses enrolled in a post-secondary educational program on a full time basis must verify educational admission or enrollment as a full time student every 90 days once the patron is enrolled in care. If, at the time of verification, the spouse is not currently enrolled, they must show proof of resumption of full time student status within 30 days or the child may be removed from care.

5. NOTIFICATION TO PATRONS. At the time of enrollment, CDPs must notify patrons in Priority 1C and lower, in writing, that they may be supplanted if a patron in a higher priority requires child care. The CDP must also provide notice of discontinued child care to patrons affected a minimum of 45 days before child care termination.

6. TYPES OF CARE. The types of care offered for children from birth through 12 years of age include 24/7 care and care provided on a full-day, part-day, short-term, or intermittent basis.

a. Military-Operated CDPs. Military-operated (on and off installation) CDPs generally include:

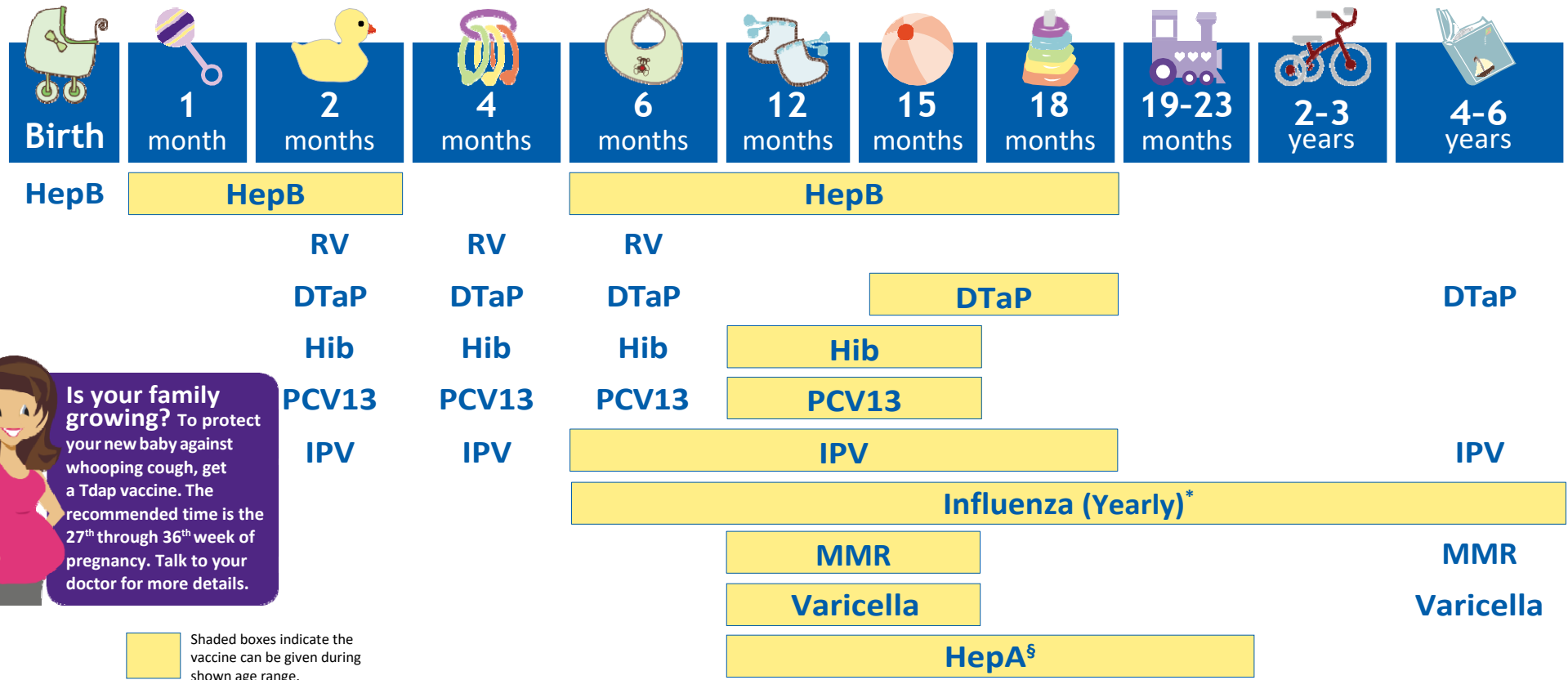
(1) CDCs. Reference Table 1 of Enclosure 3 of this Instruction for standards of operation for CDCs. CDCs primarily offer care to children from birth to 5 years of age, but may also be used to provide SAC programs.

(2) SAC Programs. Reference Table 1 of Enclosure 3 for SAC standards of operation. SAC programs primarily offer care to children from 6 to 12 years of age. Care may be offered in CDCs and other installation facilities, such as youth centers and schools.

(3) FCC. Reference Table 2 of Enclosure 3 for FCC standards of operation. Child care services are available to children from infancy through 12 years of age and are provided in government housing or in state licensed/regulated homes in the community.

(4) Supplemental Child Care. Services include short-term alternative child care options in approved settings on and off installation.

# 2021 Recommended Immunizations for Children from Birth Through 6 Years Old



**Is your family growing?** To protect your new baby against whooping cough, get a Tdap vaccine. The recommended time is the 27<sup>th</sup> through 36<sup>th</sup> week of pregnancy. Talk to your doctor for more details.

Shaded boxes indicate the vaccine can be given during shown age range.

**NOTE:** If your child misses a shot, you don't need to start over. Just go back to your child's doctor for the next shot. Talk with your child's doctor if you have questions about vaccines.

**FOOTNOTES:**  
 \* Two doses given at least four weeks apart are recommended for children age 6 months through 8 years of age who are getting an influenza (flu) vaccine for the first time and for some other children in this age group.  
 § Two doses of HepA vaccine are needed for lasting protection. The first dose of HepA vaccine should be given between 12 months and 23 months of age. The second dose should be given 6 months after the first dose. All children and adolescents over 24 months of age who have not been vaccinated should also receive 2 doses of HepA vaccine.  
*If your child has any medical conditions that put him at risk for infection or is traveling outside the United States, talk to your child's doctor about additional vaccines that he or she may need.*

See back page for more information on vaccine-preventable diseases and the vaccines that prevent them.

For more information, call toll-free 1-800-CDC-INFO (1-800-232-4636) or visit [www.cdc.gov/vaccines/parents](http://www.cdc.gov/vaccines/parents)



U.S. Department of Health and Human Services  
Centers for Disease Control and Prevention



American Academy of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™



## Vaccine-Preventable Diseases and the Vaccines that Prevent Them


Disease	Vaccine	Diseasespreadby	Disease symptoms	Disease complications
<b>Chickenpox</b>	Varicella vaccine protects against chickenpox.	Air, direct contact	Rash, tiredness, headache, fever	Infected blisters, bleeding disorders, encephalitis (brain swelling), pneumonia (infection in the lungs)
<b>Diphtheria</b>	DTaP* vaccine protects against diphtheria.	Air, direct contact	Sore throat, mild fever, weakness, swollen glands in neck	Swelling of the heart muscle, heart failure, coma, paralysis, death
<b>Hib</b>	Hib vaccine protects against <i>Haemophilus influenzae</i> type b.	Air, direct contact	May be no symptoms unless bacteria enter the blood	Meningitis (infection of the covering around the brain and spinal cord), intellectual disability, epiglottitis (life-threatening infection that can block the windpipe and lead to serious breathing problems), pneumonia (infection in the lungs), death
<b>Hepatitis A</b>	HepA vaccine protects against hepatitis A.	Direct contact, contaminated food or water	May be no symptoms, fever, stomach pain, loss of appetite, fatigue, vomiting, jaundice (yellowing of skin and eyes), dark urine	Liver failure, arthralgia (joint pain), kidney, pancreatic and blood disorders
<b>Hepatitis B</b>	HepB vaccine protects against hepatitis B.	Contact with blood or body fluids	May be no symptoms, fever, headache, weakness, vomiting, jaundice (yellowing of skin and eyes), joint pain	Chronic liver infection, liver failure, liver cancer
<b>Influenza (Flu)</b>	Flu vaccine protects against influenza.	Air, direct contact	Fever, muscle pain, sore throat, cough, extreme fatigue	Pneumonia (infection in the lungs)
<b>Measles</b>	MMR** vaccine protects against measles.	Air, direct contact	Rash, fever, cough, runny nose, pink eye	Encephalitis (brain swelling), pneumonia (infection in the lungs), death
<b>Mumps</b>	MMR** vaccine protects against mumps.	Air, direct contact	Swollen salivary glands (under the jaw), fever, headache, tiredness, muscle pain	Meningitis (infection of the covering around the brain and spinal cord), encephalitis (brain swelling), inflammation of testicles or ovaries, deafness
<b>Pertussis</b>	DTaP* vaccine protects against pertussis (whooping cough).	Air, direct contact	Severe cough, runny nose, apnea (a pause in breathing in infants)	Pneumonia (infection in the lungs), death
<b>Polio</b>	IPV vaccine protects against polio.	Air, direct contact, through the mouth	May be no symptoms, sore throat, fever, nausea, headache	Paralysis, death
<b>Pneumococcal</b>	PCV13 vaccine protects against pneumococcus.	Air, direct contact	May be no symptoms, pneumonia (infection in the lungs)	Bacteremia (blood infection), meningitis (infection of the covering around the brain and spinal cord), death
<b>Rotavirus</b>	RV vaccine protects against rotavirus.	Through the mouth	Diarrhea, fever, vomiting	Severe diarrhea, dehydration
<b>Rubella</b>	MMR** vaccine protects against rubella.	Air, direct contact	Sometimes rash, fever, swollen lymph nodes	Very serious in pregnant women—can lead to miscarriage, stillbirth, premature delivery, birth defects
<b>Tetanus</b>	DTaP* vaccine protects against tetanus.	Exposure through cuts in skin	Stiffness in neck and abdominal muscles, difficulty swallowing, muscle spasms, fever	Broken bones, breathing difficulty, death


\* DTaP combines protection against diphtheria, tetanus, and pertussis.


\*\* MMR combines protection against measles, mumps, and rubella.


Talk to your child’s doctor or nurse about the vaccines recommended for their age. COVID-19 vaccination is recommended for some adolescents.

	Flu Influenza	Tdap Tetanus, diphtheria, pertussis	HPV Human papillomavirus	Meningococcal		Pneumococcal	Hepatitis B	Hepatitis A	Polio	MMR Measles, mumps, rubella	Chickenpox Varicella
				MenACWY	MenB						
7-8 Years	Green	Orange		Orange		Orange	Orange	Orange	Orange	Orange	Orange
9-10 Years	Green	Orange	Orange, Blue	Orange	Orange	Orange	Orange	Orange	Orange	Orange	Orange
11-12 Years	Green	Orange	Orange	Orange	Orange	Orange	Orange	Orange	Orange	Orange	Orange
13-15 Years	Green	Orange	Orange	Orange	Orange	Orange	Orange	Orange	Orange	Orange	Orange
16-18 Years	Green	Orange	Orange	Orange, Green	Orange, Blue	Orange	Orange	Orange	Orange	Orange	Orange
<b>More information:</b>	Everyone 6 months and older should get a flu vaccine every year.	All 11- through 12- year olds should get one shot of Tdap.	All 11- through 12- year olds should get a 2-shot series of HPV vaccine. A 3-shot series is needed for those with weakened immune systems and those who start the series at 15 years or older.	All 11- through 12- year olds should get one shot of meningococcal conjugate (MenACWY). A booster shot is recommended at age 16.	Teens 16–18 years old <b>may</b> be vaccinated with a serogroup B meningococcal (MenB) vaccine.						

 These shaded boxes indicate when the vaccine is recommended for all children unless your doctor tells you that your child cannot safely receive the vaccine.

 These shaded boxes indicate the vaccine should be given if a child is catching up on missed vaccines.

 These shaded boxes indicate the vaccine is recommended for children with certain health or lifestyle conditions that put them at an increased risk for serious diseases. See vaccine-specific recommendations at [www.cdc.gov/vaccines/hcp/acip-recs/](http://www.cdc.gov/vaccines/hcp/acip-recs/).

 This shaded box indicates children not at increased risk may get the vaccine if they wish after speaking to a provider.



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## Vaccine-Preventable Diseases and the Vaccines that Prevent Them

Disease	Vaccine	Disease spread by	Disease symptoms	Disease complications
<b>Chickenpox</b>	Varicella vaccine protects against chickenpox.	Air, direct contact	Rash, tiredness, headache, fever	Infected blisters, bleeding disorders, encephalitis (brain swelling), pneumonia (infection in the lungs)
<b>Diphtheria</b>	Tdap* and Td** vaccines protect against diphtheria.	Air, direct contact	Sore throat, mild fever, weakness, swollen glands in neck	Swelling of the heart muscle, heart failure, coma, paralysis, death
<b>Hepatitis A</b>	HepA vaccine protects against hepatitis A.	Direct contact, contaminated food or water	May be no symptoms, fever, stomach pain, loss of appetite, fatigue, vomiting, jaundice (yellowing of skin and eyes), dark urine	Liver failure, arthralgia (joint pain), kidney, pancreatic and blood disorders
<b>Hepatitis B</b>	HepB vaccine protects against hepatitis B.	Contact with blood or body fluids	May be no symptoms, fever, headache, weakness, vomiting, jaundice (yellowing of skin and eyes), joint pain	Chronic liver infection, liver failure, liver cancer
<b>Human Papillomavirus</b>	HPV vaccine protects against human papillomavirus.	Direct skin contact	May be no symptoms, genital warts	Cervical, vaginal, vulvar, penile, anal, oropharyngeal cancers
<b>Influenza (Flu)</b>	Flu vaccine protects against influenza.	Air, direct contact	Fever, muscle pain, sore throat, cough, extreme fatigue	Pneumonia (infection in the lungs)
<b>Measles</b>	MMR*** vaccine protects against measles.	Air, direct contact	Rash, fever, cough, runny nose, pink eye	Encephalitis (brain swelling), pneumonia (infection in the lungs), death
<b>Meningococcal Disease</b>	MenACWY and MenB vaccines protect against meningococcal disease.	Air, direct contact	Sudden onset of fever, headache, and stiff neck, dark purple rash	Loss of limb, deafness, nervous system disorders, developmental disabilities, seizure disorder, stroke, death
<b>Mumps</b>	MMR*** vaccine protects against mumps.	Air, direct contact	Swollen salivary glands (under the jaw), fever, headache, tiredness, muscle pain	Meningitis (infection of the covering around the brain and spinal cord), encephalitis (brain swelling), inflammation of testicles or ovaries, deafness
<b>Pertussis</b>	Tdap* vaccine protects against pertussis.	Air, direct contact	Severe cough, runny nose, apnea (a pause in breathing in infants)	Pneumonia (infection in the lungs), death
<b>Pneumococcal Disease</b>	Pneumococcal vaccine protects against pneumococcal disease.	Air, direct contact	May be no symptoms, pneumonia (infection in the lungs)	Bacteremia (blood infection), meningitis (infection of the covering around the brain and spinal cord), death
<b>Polio</b>	Polio vaccine protects against polio.	Air, direct contact, through the mouth	May be no symptoms, sore throat, fever, nausea, headache	Paralysis, death
<b>Rubella</b>	MMR*** vaccine protects against rubella.	Air, direct contact	Sometimes rash, fever, swollen lymph nodes	Very serious in pregnant women—can lead to miscarriage, stillbirth, premature delivery, birth defects
<b>Tetanus</b>	Tdap* and Td** vaccines protect against tetanus.	Exposure through cuts on skin	Stiffness in neck and abdominal muscles, difficulty swallowing, muscle spasms, fever	Broken bones, breathing difficulty, death

\*Tdap combines protection against diphtheria, tetanus, and pertussis.

\*\*Td combines protection against diphtheria and tetanus.

\*\*\*MMR combines protection against measles, mumps, and rubella.

If you have any questions about your child's vaccines, talk to your child's doctor or nurse.