

CYSS Teen Packet



U.S. Army Child, Youth & School Services

Items you will need for Teen (6th-12th grade) registrations:

- Completed Forms

If you have any questions, or wish to set up an appointment: please call Parent Central Services at 361-7713. You may also reach the Parent and Outreach Services Director at 361-7372.

**Army Child Youth & School Services (CYSS)
Middle School Teen (MST)
Program Registration & Sponsor Consent**

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, United States Code, Section 3012. **PRINCIPAL PURPOSE(S):** To provide child and family program eligibility, background information and sponsor consent for access to emergency medical care. **ROUTINE USES:** Information is furnished to the attending physician when it is necessary for an individual to be taken to a medical facility by someone other than the parent. **DISCLOSURE:** Disclosure of requested information is voluntary, however, if information is not provided, individual(s) may not be allowed to participate in the CYSS Program

DECLARATION OF NONDISCRIMINATION

Services will be made available to all youth in attendance, without regard to race, religion, national origin, ancestry, or sex, within the limits of AR 608-10

YOUTH: Last Name: _____ First Name: _____ Nickname: _____

Address: _____ City: _____ Zip Code: _____

Gender: (circle one) M / F Grade: _____ School: _____ DOB: _____ Age: _____

E-Mail Address: _____

I want to receive email information and announcements about CYSS Programs and event: Yes _____ No _____

Home Phone Number: _____ Cell Phone Number: _____

PARENT SPONSOR: Last Name: _____ First Name: _____

Status: (circle one) Active Duty / Guard / Reserve / DoD Civilian / Other: _____ (Military: Rank: _____)

Branch of Service: (circle one) AR / SF / NA / MA / CG Unit/Employer: _____

Installation: _____ Work Phone Number: _____ Cell Phone Number: _____

Mailing Address: _____ City: _____ Zip Code: _____

Home Phone Number: _____ On-Post? Yes: _____ No: _____

E-Mail Address: _____

PARENT: Last Name: _____ First Name: _____

Status: (circle one) Active Duty / Guard / Reserve / DoD Civilian / Non DoD Civ. / Student / Retired / Unemployed / Other: _____

Branch of Service: (circle one) AR / SF / NA / MA / CG Unit/Employer: _____ (Military: Rank: _____)

Unit/Employer Address: _____

Work Phone Number: _____ Cell Phone Number: _____ Home Phone Number: _____

E-Mail Address: _____

CENTRAL ENROLLMENT REGISTRATION (CER) STAFF TELEPHONIC VERIFICATION:

NAME OF VERIFYING PARENT: Last Name: _____ First Name: _____

Staff Name: _____ Verification Date: _____ Time: _____

Special Needs? Yes: _____ No: _____ If yes, date DA Form 7625-1 sent to Parent: _____ Date Returned: _____

Date CYSS Pass Issued: _____ CER Staff Signature: _____

Other Information: _____

EMERGENCY CONTACTS INFORMATION: (Local adults, other than sponsor and spouse, authorized to respond in an emergency):

1. Last Name: _____ First Name: _____ Work Phone: _____
Cell Phone: _____ Home Phone: _____
Is this person authorized to pick up youth? Yes: _____ No: _____

2. Last Name: _____ First Name: _____ Work Phone: _____
Cell Phone: _____ Home Phone: _____
Is this person authorized to pick up youth? Yes: _____ No: _____

SPONSOR CONSENT: Parent/Guardian of _____, give consent for an authorized CYSS representative to obtain medical/dental care for my youth in an emergency situation where his/her condition represents a serious or imminent threat to his/her life, health, or well being. I understand that a conscientious effort will be made to notify me prior to such action and the expense, if any will be paid by me. Treatment at an Army medical facility may be provided without additional consent under the provision of AR 400-3.
Yes: _____ No: _____

Does your Youth have any special needs (asthma, allergies, ADHD, physical disabilities, dietary restrictions, etc.) Yes: _____ No: _____
(If Yes, DA Form 7625-1 will be sent to you for completion and must be returned within 5 days.)

Can your Youth be photographed while participating in a CYSS Program for release to the media? Yes: _____ No: _____

Does your Youth have permission to use the CYSS Computers provided in the Technology Lab? Yes: _____ No: _____

If Yes, does your Youth have permission to access the internet? Yes: _____ No: _____

Does your Youth have permission to travel in a government/rental vehicle to participate in Youth Programs? Yes: _____ No: _____

Name of CER Staff member verifying the information: _____

Please Print Name

Date: _____ CER STAFF SIGNATURE: _____

MST STAFF CONTACT: Name of Parent Contacted: _____

Staff Name: _____ Contact Date: _____ Time: _____

Other Information: _____

Child Youth & School Services Registration Card
DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, United States Code, Section 3013. **PRINCIPAL PURPOSE(S):** Information is used by DA personnel to identify children enrolled in Child Youth & School Services (CYSS), their sponsors, and persons to contact in the event of an emergency involving such children. **ROUTINE USES:** Information may be released to other DOD Personnel who have a need for the information in the course of performing their official duties. **DISCLOSURE:** Disclosure of requested information is voluntary, however, if information is not provided, enrollment in Child Youth & School Services (CYSS) may be denied.

Child Name: _____ Grade: _____

Part A:

I _____ CONSENT TO THE FOLLOWING IN REFERENCE TO THE CARE OF MY CHILD/CHILDREN.

- Release of photographs of my child/children to the media for purpose of publicizing Child Youth & School Services (CYSS) activities. Yes: _____ No: _____
- Participation by my child/children in on/off post field trips or other similar activities when accompanied and supervised by Child Youth & School Services (CYSS) personnel. Yes: _____ No: _____
- Transportation in a government or commercial vehicle. Yes: _____ No: _____
- Transportation in a private vehicle in an emergency medical situation. Yes: _____ No: _____

I authorize Child Youth & School Services (CYSS) representatives to take my child/children for care, medical or dental, in an emergency situation where the child's condition represents a serious or imminent threat to his/her life, health or well being. I understand that a conscientious effort will be made to notify me prior to such and the expense, if any, will be borne by me.

Parent/Guardian Signature: _____ Date: _____

Part B: (Please it is important that both A & B be completed in full!)

In order to best serve you and your child/children, please give us any information about your child which will ensure he/she has a rewarding experience with us. Please tell us if your child/children has/have a special physical or medical need we should know about. Does your child/children take a medication of any kind? If so, please provide details.

- a) _____ My child/children (at this) time has NO special physical or medical needs. (Proceed to B if Checked)

Please complete the following if your child/children has/have and special physical or medical needs:

- 1) Does he/she have Asthma? Yes: _____ No: _____
 - i. If yes, what triggers that Asthma? _____
 - ii. When was the last attack? _____
 - iii. Does he/she use an inhaler, nebulizer or take an oral medication? Yes: _____ No: _____
- 2) Does he/she have ADHD/ADD/ODD? Yes: _____ No: _____
 - i. If yes, please check which one applies: ADHA: _____ ADD: _____ ODD: _____
 - ii. Does he/she take medication for this? Yes: _____ No: _____

3) Does he/she have any food allergies? Yes: _____ No: _____

i. If yes, what if he/she allergic to? _____

4) Does he/she have any other medical conditions that we need to be aware of? Yes: _____ No: _____

i. If yes, what are those conditions? _____

ii. Does he/she take medication for this condition? Yes: _____ No: _____

b) _____ My child/children (at this) time DOES NOT self medicate.

Please complete the following ONLY if you are allowing your child to self-medicate.

I authorize my child/children _____ to self-administer the following medication, while attending the Middle School Teen Program (MST) and I understand that the MST staff will not administer any medication.

Name of Medication(s): _____ Time(s) medication to be taken: _____

CONTINUED FROM PAGE 3, THESE ARE TO BE KEPT TOGETHER.



U.S. Army Child, Youth
& School Services

**FORT WAINWRIGHT YOUTH SERVICES
ETHNIC GROUP QUESTIONNAIRE**

Youth Services is an affiliate member of **BOYS & GIRLS CLUBS OF AMERICA**. As a member, we are asked to keep the same statistics they keep, one of which is ethnic group. This information is only for the reporting purposes and will not be used by Youth Services. Please check the box of your child/children ethnic background. If you feel no category properly describes your child/children ethnic background, please check the one most closely related to the child/children observable characteristics.

YOUTH NAME: _____ Date: _____

- Caucasian
- Black/African American
- Asian
- Native American/Alaska
- Hispanic
- Multiracial



U.S. Army Child, Youth
& School Services

FORT WAINWRIGHT YOUTH TECHNOLOGY LAB PARENT PERMISSION/AGREEMENT CARD FOR INTERNET USE (1)

Child/Children Name: (Print) _____ Youth Age: _____

I give my child/children, _____, permission to use the internet at the Fort Wainwright Youth Technology Lab, and Agree to the INTERNET use policy.

POLICIES:

- 1) All children/youth using the YOUTH TECHNOLOGY LAB must abide by all YOUTH TECHNOLOGY LAB RULES.
- 2) Inappropriate language, swearing, abusive language is forbidden.
- 3) Using another person's USER ID or password without permission is prohibited.
- 4) Illegal activities are strictly forbidden. It is illegal to hack or gain illegal entry into other computers.
- 5) Youth will not use the network in such a way as to disrupt the use of the network by others.
- 6) The writer of a message must sign the message. Messages may not be sent anonymously.
- 7) Youth should understand privacy is NOT guaranteed when using the Internet and services associated with Internet traffic. Youth will always be supervised when in the YOUTH TECHNOLOGY LAB.
- 8) Any use of the network product advertisement or political lobbying is prohibited. Children/Youth may not order products or services on the network.
- 9) Personal addresses, phone numbers and personal data of children/youth are not to be revealed over the INTERNET.
- 10) Chat Rooms are strictly prohibited.
- 11) Users must abide by copyright laws.
- 12) The YTL Instructor or YS Staff member reserves the right to remove a user from the lab/network if these policies are not followed.
- 13) This permission form does not eliminate the requirement for Basic Computer Skills Training or Internet Use Test and as always parents are responsible for the actions of their child/youth.
- 14) Visiting any site with adult content or listening to any audio file that contains explicit lyrics is strictly prohibited.

I agree to hold the FORT WAINWRIGHT CHILD YOUTH & SCHOOL SERVICES COORDINATOR, DIRECTORS, and other staff harmless for any consequences resulting from the use of the INTERNET, E-Mail, or creation of Digital Pictures and Video.

Parent/Guardian Signature: _____ Date: _____

Child/Youth Signature: _____ Date: _____

PRIVACY ACT STATEMENT

AUTHORITY: Title 5, United States Code, Section 301, and E.O. 9307. **PRINCIPAL PURPOSE(S)/ROUTINE USE:** Information is needed for contacting participants and parents utilizing CYSS Facilities. **DISCLOSURE:** Voluntary; however, failure to provide requested information may result in the child/children not being able to participate in some CYSS Programs.

FORT WAINWRIGHT YOUTH TECHNOLOGY LAB PARENT PERMISSION/AGREEMENT CARD FOR INTERNET USE (2)

I, _____, understand the INTERNET USE AGREEMENT. I further understand that any violation of the regulations can be a violation of local, state, and federal laws and that I can be prosecuted for violating those laws. Should I commit any violations, my access privileges may be revoked, disciplinary action may be taken, and/or appropriate legal action may be taken.

Youth Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____



U.S. Army Child, Youth
& School Services

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; 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.

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. SSN (last four digits)
8. Spouse name		
9. Home phone	10. Duty phone	11. Cell phone

Part B - Identification of Child/Youth Condition/Restrictions

Child has any of the following conditions/restrictions: (Check yes or no)

1. Allergies	
<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
a. Life threatening reaction	
<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
b. Epi-pen required	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
c. Other allergic reactions (hives, rash, diarrhea)	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
2. Asthma reactive airway disease	
<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
a. Triggers exist for child's asthma attacks (stress, environmental, exercise)	
<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
b. Child routinely (greater than 10 days per month/four months per year) uses inhaled anti-inflammatory agents and/or bronchodilators	
<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
c. Child has taken steroids during the past year (prednisone, prednisolone)	
<input type="checkbox"/> No	<input type="checkbox"/> Yes (indicate number of days in past year)

d. Child has experienced unconsciousness or seizures associated with asthma attacks	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
e. Child required an urgent visit to emergency room or clinic for acute asthma within the last 12 months	<input type="checkbox"/> No	<input type="checkbox"/> Yes (indicate number of visits in the past year)
f. Child has been hospitalized for asthma related condition in the past six months	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
3. Attention Deficit Disorder (ADD)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
a. ADD with hyperactivity	<input type="checkbox"/> No	<input type="checkbox"/> Yes
b. Is not well controlled with medication	<input type="checkbox"/> No	<input type="checkbox"/> Yes (not well controlled)
c. Behavioral/conduct concerns	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
4. Autism	<input type="checkbox"/> No	<input type="checkbox"/> Yes
5. Behavioral/conduct concerns (for example, oppositional defiant disorder, anxiety disorder, school phobias)	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
6. Blindness/visual problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
7. Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
8. Emotional problems that require care by a psychiatrist, psychologist or social worker	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
9. Epilepsy	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
10. Hearing problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
11. Heart problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
12. Kidney problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
13. Speech/language delay	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
14. Physical disability	<input type="checkbox"/> No	<input type="checkbox"/> Yes (explain)
15. Dietary restrictions	<input type="checkbox"/> No	<input type="checkbox"/> 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)