

CYSS Registration Packet



U.S. Army Child, Youth & School Services

Items you will need for registration:

- Completed Registration Packet
- Complete Shot Records
- Required HEP A shot and PPD skin test.... See note below
- LES Statement and Paystubs for sponsor and spouse
- Military Orders for Deployed Sponsors and WTU Members

If your child does not have the required HEP A shot for children over 2 and the PPD Skin Test for children over 1, you can take them to the walk in clinic at Basset Army Community Hospital. Registration cannot be completed and your child cannot participate in CYSS programs until these required immunizations have been documented by CYSS Parent Central Services.

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 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)

Ft. Wainwright Child and Youth Services Request For Childcare Form

1. Today's Date:	2. Time:	3. Date Care is Needed:	4. Confirmation Date:	5. Date Entered on Waitlist:
6. Family Data: Sponsor Information Name: (Last, First, MI)			7. Family Data: Spouse Information Name: (Last, First, MI)	
Home Address: Rank: _____ Unit: _____			Home Address: Rank: _____ Employer: _____	
Home #: _____ Unit Phone#: _____		Cell #: _____ Work #: _____		
8. Family Data: Child's Information Child's Name (Last, First, MI)			Child's DOB: (MMDDYY) Age: _____ Sex: _____ Due Date for unborn: _____	
9. Ethnicity: Circle appropriate one (White/Caucasian) (Black/African American) (American Indian/Alaska native) (Cuban) (Mexican, Mexican-American, Chino) (Puerto Rican) (Other Spanish /Hispanic/Latino) (Asian Indian) (Chinese) (Filipino) (Japanese) (Korean) (Vietnamese) (other Asian) (Guamanian/Chamorro) (Native Hawaiian) (Samoan) (Other Pacific Islander) (Multi-Racial/Other (not listed))				
11. Status: (X applicable areas) <input type="checkbox"/> Military <input type="checkbox"/> CYS employee <input type="checkbox"/> Contractor <input type="checkbox"/> DOD Civilian <input type="checkbox"/> On Post: _____ <input type="checkbox"/> Not presently in care: _____ <input type="checkbox"/> Off Post: _____ <input type="checkbox"/> Other: _____				
12. Present Child Care Arrangements				
13. General Information: (Circle appropriate/response) Yes/No Is child on other military waiting list? (If yes, provide name of installation)				
Yes/No Has your child been identified for special needs care? (If yes, specify i.e. asthma, food allergy, etc)				
School: Age Info		Grade: _____ Choose Program Option(s): Check appropriate areas		
Name of School		<input type="checkbox"/> Infants <input type="checkbox"/> Toddlers <input type="checkbox"/> Full Day Preschool <input type="checkbox"/> Sports Only <input type="checkbox"/> STACC Care only <input type="checkbox"/> Hourly Care <input type="checkbox"/> Part Day Preschool: _____ 2 Day _____ 3 Day _____ 5 Day _____ Kindergarten: _____ Before /After _____ Before Only <input type="checkbox"/> Summer Camp Only <input type="checkbox"/> School age Services: _____ Before/After Care _____ After Only _____ Summer Camp Only		
I understand that I am obligated to contact the Central Registration Office at 361-7395 or 361-9056 within 30 days of submitting this waitlist request to maintain placement on the waitlist. I understand that I must call every 30 days until I am offered placement to confirm my need for care. Failure to confirm status will result in removal from the waitlist.				
Parent's Signature: _____			Date: _____	

APPLICATION FOR DEPARTMENT OF DEFENSE CHILD CARE FEES

PRIVACY ACT STATEMENT

AUTHORITY: Public Law 101-189, Section 1504; E.O. 9397.

PRINCIPAL PURPOSE(S): To collect total family income data to determine child care fees.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary; however, failure to furnish information will result in placement in the highest fee range.

SECTION I - DEPENDENT CHILDREN

To determine child care fees for your child(ren), or any child(ren) you legally claim as your dependent(s), you must complete, sign, and return this form to the director of the program you are applying for. Fees will be determined based on your total family income as defined below. If you do not wish to disclose your total family income, your rate will be set automatically at the highest fee level.

1. NAME OF EACH CHILD <i>(LAST, First, Middle Initial)</i>	2. DATE OF BIRTH <i>(YYYYMMDD)</i>	3. AGE	4. CARE REQUESTED
a.			
b.			
c.			
d.			
e.			

SECTION II - ANNUAL FAMILY INCOME *(To be completed by sponsor. Include all military and civilian earned income for sponsor and spouse.)*

Enter your annual income data as requested; e.g., multiply the most recent monthly income by 12 or if paid on a biweekly income, enter the most recent biweekly income and multiply by 26. For purpose of determining child care fees in DoD Child Care program, total family income is defined as all earned income including wages, salaries, tips, long-term disability benefits, combat pay and voluntary salary deferrals. Include all earned income such as wages, salaries, tips, long-term disability benefits, voluntary salary deferrals, retirement or other pension income, etc., before deductions for taxes, social security, etc. Include quarters subsistence and other allowances appropriate for the rank and status of military or civilian personnel whether received in cash or in kind. For dual military living in government quarters include BAH-II of senior member only. Include anything else of value, even if not taxable, that was received for providing services. **DO NOT INCLUDE** cost of living allowance (COLA) received in high cost areas, alimony and child support, temporary duty allowances or reimbursements for educational expenses.

5. SPONSOR			
a. NAME <i>(LAST, First, Middle Initial)</i>	b. SSN	c. YEARS OF MILITARY/CIVIL SERVICE	
d. INCOME			
(1) BASE PAY <i>(Most recent leave and earnings statement)</i>	(2) BASIC ALLOWANCE FOR HOUSING <i>(Or in-kind equivalent) (Annual chart of minimum BAH-II)</i>	(3) BASIC SUBSISTENCE ALLOWANCE <i>(Or in-kind equivalent)</i>	(4) OTHER EARNED INCOME AS DESCRIBED ABOVE

6. SPOUSE		
a. NAME <i>(LAST, First, Middle Initial)</i>	b. SSN	c. YEARS OF MILITARY/CIVIL SERVICE
d. INCOME		

7. OTHER EARNED INCOME AS DESCRIBED ABOVE	8. TOTAL INCOME FOR SPONSOR, SPOUSE, AND OTHER
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SECTION III - CERTIFICATION OF SPONSOR *(Required for Category I - IV. Please read the following statement carefully before signing.)*

I certify that all of the above information is true and correct and that all family income of the spouse and sponsor is reported. I understand that this information is being given in order to determine child care fees to be paid and that Federal funds are used to subsidize the cost of child care. I also understand that the installation commander may verify the information on the application; and that deliberate misrepresentation of this information may subject me to prosecution under applicable State and Federal laws. See 18 U.S.C. Section 1001.

9. SIGNATURE OF SPONSOR*	10. SIGNATURE OF SPOUSE	11. DATE SIGNED <i>(YYYYMMDD)</i>
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**If signature is missing, the fees will automatically be placed at the highest level.*

12. TELEPHONE NUMBERS <i>(Include Area Code)</i>		13. HOME ADDRESS <i>(List apartment number and 9-digit ZIP Code)</i>
a. HOME	b. WORK	
(1) SPONSOR		
(2) SPOUSE		

SECTION IV - FOR CHILD DEVELOPMENT CENTER USE ONLY

14. CATEGORY OF APPROVAL	15. AUTHORIZED FEES
16. DATE OF APPROVAL <i>(YYYYMMDD)</i>	17. NAME OF CHILD DEVELOPMENT PROGRAM OFFICIAL

**Health Assessment / Sports Physical Statement (HASPS)
for CYS SERVICES
ENROLLEMENT, Renewal & SPORTS Physical Requirements**

Revised 12Jan 10

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	Sponsor SSN	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

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 - Hemia				
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				
PARTICIPATION RECOMMENDATIONS				
<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

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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
	<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	