

# Child & Youth Services Registration

Name of Sponsor: (Last, first MI) \_\_\_\_\_

Active Military \_\_\_ Rank \_\_\_ DOD \_\_\_ Govt. Cont. \_\_\_ Soc.Sec.# \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip code \_\_\_\_\_

Work Address \_\_\_\_\_ Bldg.# \_\_\_\_\_

Home Phone# \_\_\_\_\_ Cell # \_\_\_\_\_ Work# \_\_\_\_\_

EMAIL \_\_\_\_\_ Ethnicity \_\_\_\_\_

Name of Spouse: (Last, first, MI) \_\_\_\_\_

Active Military \_\_\_ Rank \_\_\_ DOD \_\_\_ Govt. Cont. \_\_\_ Unemployed \_\_\_\_\_

Home Address \_\_\_\_\_ Work Address \_\_\_\_\_

Home Phone# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_

EMAIL \_\_\_\_\_ Ethnicity \_\_\_\_\_

## Children:

Name \_\_\_\_\_ DOB \_\_\_\_\_ Gender \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Gender \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Gender \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Gender \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Ethnicity \_\_\_\_\_

## Emergency Contacts Other than Sponsor or Spouse:

Name \_\_\_\_\_ Child Release Designee \_\_\_\_\_

Home# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_

Name \_\_\_\_\_ Child Release Designee \_\_\_\_\_

Home# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_

Name \_\_\_\_\_ Child Release Designee \_\_\_\_\_

Home# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_

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

**Health Assessment / Sports Physical Statement (HASPS)  
for CYS SERVICES  
ENROLLEMENT, 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	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: SPORTS PHYSICAL				
Medical Staff Assessment (Completed by licensed independent practitioner)				
Age YRS	MOS	Height	Weight	
		cm. ( %ile)	kgs. ( %ile)	
BP:	P:	Visual Acuity	Tested with / without glasses	
		Right / Left /		
		NORMAL	ABNORMAL	N / A
		COMMENTS		
1. Eyes				
2. Ears, Nose & Throat				
3. Hearing				
4. Mouth & Teeth				
5. Neck (Soft tissues)				
6. Cardiovascular				
7. Chest & Lungs				
8. Abdomen				
9. Genitalia - Hernia				
10. Skin & Lymphatics				
11. Spine - Scoliosis				
12. Extremities				
13. Neurological				
14. Wears braces / plates				
Based on this HX and PX exam, the following abnormalities were found and may need treatment:				
Immunizations are current and up to date: <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"/> PA 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 Signature
Date	Type or print name of Parent or Guardian	Signature of Parent or Guardian

Health Assessment Re-Certification		
Date	Health Status Changed	Signature of Parent or Guardian
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Date	Health Status Changed	Signature of Parent or Guardian
	<input type="checkbox"/> Yes <input type="checkbox"/> No	

# 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)	
<div style="font-size: 2em; font-weight: bold; opacity: 0.5;">email</div>		
3. Type of placement requested	5. Date (YYYYMMDD)	
4. Sponsor name	7. SSN (last four digits)	
6. 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)

Dear Patron,

Redstone Arsenal no longer has a Hospital to provide emergency services. The Fox Army Hospital is now a Super Clinic. It was converted to a Super Clinic in 1999. They Will not handle any type of emergencies. Therefore, if a child attending any Child and Youth Service Program experiences any kind of Medical Emergency 911 will be called. Currently the 911 calls are answered at the Post Fire Department who in turn contacts HEMSI in the event an Ambulance is required.

Your Health Insurance plan most likely requires that you receive services provided by a specific Hospital or Physician Group. To help us prevent unnecessary financial hardship to you we respectfully request that you take time to fill out the information below.

B. ANDRE TERRY  
Chief, Child and Youth Services

In the event of a Medical Emergency, I request that my child:

\_\_\_\_\_

Be transported to:    Huntsville Hospital     Crestwood Hospital

Sponsor/Spouse Signature \_\_\_\_\_ Date \_\_\_\_\_

## CHILD DEVELOPMENT SERVICES (CDS) SPONSOR CONSENT

For use of this form, see AR 608-10; the proponent agency is DCSPER

I, \_\_\_\_\_ parent/guardian of \_\_\_\_\_ consent\*  
to the following in reference to the care of my child/children.

	CHECK	
	YES	NO
USE OF PHOTOGRAPHS FOR RELEASE TO MEDIA	<input type="checkbox"/>	<input type="checkbox"/>
PARTICIPATION IN ON-AND-OFF POST EXCURSIONS ACCOMPANIED BY CDS PERSONNEL	<input type="checkbox"/>	<input type="checkbox"/>

INDEPENDENT PARTICIPATION IN ATHLETIC EVENTS, CLASSES, YOUTH ORGANIZATIONS AND CLUBS, WALKING TO AND FROM SCHOOL, VISITING FRIENDS, OR OTHER ACTIVITIES LISTED BELOW.

ACTIVITY	LOCATION	ARRIVE	DEPART	DAYS	DATES

	CHECK	
	YES	NO
TRANSPORTATION IN A GOVERNMENT OR COMMERCIAL VEHICLE	<input type="checkbox"/>	<input type="checkbox"/>
TRANSPORTATION IN A PRIVATE VEHICLE	<input type="checkbox"/>	<input type="checkbox"/>
OTHER-	<input type="checkbox"/>	<input type="checkbox"/>
OTHER-	<input type="checkbox"/>	<input type="checkbox"/>
OTHER-	<input type="checkbox"/>	<input type="checkbox"/>
REMARKS		

*\*Sponsor consent for access to emergency medical or dental treatment is contained in DA Form 4719-R. Sponsor consent for administration of medication is contained on DA Form 5225-R*

SIGNATURE OF SPONSOR	DATE
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IMSE-RED-MW

MEMORANDUM FOR RECORD

SUBJECT: Child, Youth, & School Services (CYSS) Eligibility Criteria

1. Reference Army Regulation 608-10, Child Development Services, 15 July 1997, paragraph 1-6.
2. Child eligibility criteria - Active duty military personnel, appropriated fund and non appropriated fund Department of Defense (DOD) civilian personnel, reservists on active duty or during inactive duty personnel training, and DOD contractors are eligible to use all Army operated or sponsored child development programs such as Child Development Centers, Family Child Care, and Supplemental Programs and Services.
3. Any active duty military member who accepts a slot at a CYSS facility and later retires or goes on reserve status (if neither sponsor nor spouse works on Redstone Arsenal) may remain in the facility, contingent upon waiting list status. However, if at a later date, there are eligible candidates requiring care in a particular age group, the Family **will lose** their space to an Active, eligible customer.
4. My point of contact is Mr. B. Andre Terry, Chief, CYSS, 256-955-8035, [andre.terry@us.army.mil](mailto:andre.terry@us.army.mil)



DERRICK E. GOULD  
Director, Directorate of Family and  
Morale, Welfare and Recreation

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

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

#### 6. SPOUSE

a. NAME <small>(LAST, First, Middle Initial)</small>	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	

#### 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 <small>(YYYYMMDD)</small>
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\*If signature is missing, the fees will automatically be placed at the highest level.

12. TELEPHONE NUMBERS <small>(Include Area Code)</small>		13. HOME ADDRESS <small>(List apartment number and 9-digit ZIP Code)</small>
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 <small>(YYYYMMDD)</small>	17. NAME OF CHILD DEVELOPMENT PROGRAM OFFICIAL