

RE-REGISTRATION W/SAC SIBLING



Parent Central Services Registration Checklist

SAC McConnell Youth Center



Phone: 717.245.3801

459 Fletcher Rd.

Children/Youth must be fully registered before they can use any CYS Services Program.

To expedite the registration process, please have the following information available.

ITEMS/INFORMATION FOR REGISTRATION	VERIFICATION
Program Information Form Local Emergency and Child Release Designees (minimum of 2) (names/phone numbers - if you are unable to be reached in case of emergency, designees will be called and must live within 30 minutes of Carlisle Barracks) *Must be two people other than sponsor & spouse*	
Child's Official Shot Record (fifth grade and below, Homeschool, and Private School)	
Family Care Plans DA5305 (Required for single/dual military and single/dual deployable civilian families) (Due 30 days from enrollment in part/full time programs)	
Health Screening Tool-1 (To record/evaluate child's allergies, medical/physical conditions, etc. for all children birth through 5 th grades and ALL Youth identified as having special needs)	
Medical Action Plan (MAP) Only needed if a child is diagnosed with allergies, diabetes, asthma/respiratory or seizures that requires staff to give rescue medications) (If recommended by Special Needs Assessment Team) (New Medical Action Plans are required yearly at re-registration)	
Liability Waiver Form	

Comments: _____

Registration completed by: _____ Date: _____



Child and Youth Services Program Information Form

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Date: _____

AUTHORITY: Title 10, United States Code, Section 3012, DoDI 6060.02, DoDI 6060.4, AR 608-10, and AR 215-1.

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 of requested information is voluntary, however, if information is not provided, individual(s) may not be allowed to participate in the CYS 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.

SPONSOR: Last Name _____ First Name _____ Rank _____
Status _____ Specify if Other _____ Branch _____
Unit/Employer _____ Unit/Employer Address _____ Zip Code _____
Installation _____ Work Phone _____ Cell Phone _____
Home Phone _____ Home Address _____ Zip Code _____
On Post? _____ Sponsor Primary Email Address _____ Alternate _____

SPOUSE: Last Name _____ First Name _____ Rank _____
Status _____ Specify if Other _____ Branch _____
Unit/Employer _____ Unit/Employer Address _____ Zip Code _____
Work Phone _____ Cell Phone _____ Home Phone _____
Spouse Primary Email Address _____ Alternate _____

Child's Name: _____ DOB: _____ Grade: _____ School: _____
Child's Name: _____ DOB: _____ Grade: _____ School: _____
Child's Name: _____ DOB: _____ Grade: _____ School: _____
Child's Name: _____ DOB: _____ Grade: _____ School: _____

EMERGENCY/RELEASE CONTACTS (Local adults, not parents, authorized to respond in an emergency or locate parent):

1. Last Name _____ First Name _____ Work Phone _____
Cell Phone _____ Home Phone _____ Is this person authorized to pick-up youth? _____
2. Last Name _____ First Name _____ Work Phone _____
Cell Phone _____ Home Phone _____ Is this person authorized to pick-up youth? _____
3. Last Name _____ First Name _____ Work Phone _____
Cell Phone _____ Home Phone _____ Is this person authorized to pick-up youth? _____

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.

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

☐ Initial Registration On waiting list? ☐ Yes ☐ No Date care needed? _____	☐ Re-registration/already in program ☐ Current Program ☐ Change in Condition	Date in from Patron: _____ Date out to APHN: _____
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PART A - GENERAL INFORMATION (Parent completes)

Child/Youth's Name	Child/Youth School Grade (example: 3rd Grade)	Date of Birth (YYYY-MM-DD)	Age
Type of Program Requested (check all that apply):			
☐ Hourly Care ☐ Full Day Care ☐ Middle School/Teen Program ☐ Summer Camp ☐ Other: _____			
☐ Part Day Care ☐ Before/After School Care ☐ SKIES/Instructional Classes ☐ Sports			
Sponsor Name		Sponsor Email (AKO)	
Spouse Name		Sponsor DOB (YYYY-MM-DD)	
Home Phone		Sponsor Unit	
Cell Phone		Sponsor Duty Phone	
Home Address			

PART B - CHILD / YOUTH MEDICAL / DEVELOPMENTAL CONDITIONS (check yes or no)

Does your child/youth have:

1. Asthma/Reactive Airway Disease/Breathing Problems? ☐ Yes ☐ No a. Does it require a rescue medication? ☐ Yes ☐ No 2. Allergies? List: ☐ Yes ☐ No a. Does it require a rescue medication? ☐ Yes ☐ No 3. Dietary Restrictions? ☐ Yes ☐ No ☐ a. Medically-based ☐ b. Religiously-based 4. Diabetes? ☐ Yes ☐ No 5. Epilepsy/Seizures? ☐ Yes ☐ No 6. Attention Deficit/Hyperactivity Disorder (ADD/ADHD)? ☐ Yes ☐ No a. Is your child/youth prescribed medication? ☐ Yes ☐ No 7. Diagnosed Behavior/Conduct concerns? ☐ Yes ☐ No a. Is your child/youth prescribed medication? ☐ Yes ☐ No	8. Emotional problems/difficulties? ☐ Yes ☐ No 9. Autism Spectrum Disorder? ☐ Yes ☐ No 10. Developmental Disability? ☐ Yes ☐ No 11. Visual problems/difficulties not corrected by glasses/contacts? ☐ Yes ☐ No 12. Hearing problems/difficulties? ☐ Yes ☐ No 13. Speech/language delays? ☐ Yes ☐ No 14. Other developmental delays? ☐ Yes ☐ No 15. Physical disability? ☐ Yes ☐ No 16. Other medical condition or concerns? ☐ Yes ☐ No If yes, please explain:
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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 (YYYY-MM-DD)

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 (YYYY-MM-DD)

LIABILITY WAIVER

USAG Carlisle Barracks CYS
459 Bouquet Rd
Carlisle Barracks
Carlisle PA 17013
Phone: (717)245-4555

Sponsor's Name:

Address:

Hm Ph:

Wk Ph:

Email:

Participant:

Guardian:

MEMORANDUM FOR RECORD
SUBJECT: Child and Youth Services (CYSS) Statements of Understanding and Medical Consent Statement

- 1. Data Required by the Privacy Act of 1974
- 2. Authority. Title 10, United States Code, section 3012.
- 3. Principal Purpose. Information is used by DA personnel to: (1) provide Child and Family program eligibility and background information, (2) develop programs meeting needs of Children and Families, (3) ensure appropriate placement of Child, (4) identify contingency plan for Child illness, (5) identify emergency designees, and (6) collect data required by USDA food program.
- 4. Routine Uses. Information on immunization and medical problems will be used as part of the program admission screening procedure. Family income data will be used to determine USDA food program qualification and rate structures. Medical consent information is furnished to the attending physician when it is necessary for a child to be taken to a medical facility by someone other than the parent.
- 5. Disclosure. Disclosure of requested information is voluntary. However, if information is not provided, individuals may not be allowed to participate in Child and Youth Services (CYS) programs.
- 6. Statements of Understanding.
 - a. I have received the CYS Parent Handbook and will abide by all policies.
 - b. I acknowledge that CYS facilities are under video surveillance.
 - c. I have reviewed the Household and Family information file. To the best of my knowledge, the information provided to CYS is accurate and complete.
 - d. I consent to the following in reference to the care of my child: Yes No
 - i. Participation in on/off post excursions accompanied by CYSS personnel with prior knowledge. Yes No
 - ii. Transportation in a government or commercial vehicle is authorized for field trips or emergency situations. Yes No
 - iii. Use of photographs of my child for release to the Installation newspaper, civilian media, or to copyright and/or reuse in other military or civilian publications or on the Installation websites. Yes No
- 7. Medical Consent Statement.
 - a. I give consent by signing this agreement, for an authorized Child and Youth Services (CYS) representative to take my Child for care, medical or dental, in an emergency situation when the child's condition represents a serious or imminent threat to his/her life, health, or well-being.
 - b. I understand that a conscientious effort will be made to notify me before such action.
 - c. I will pay any expenses incurred.
 - d. Treatment at an Army medical facility may be provided without additional consent under provision of AR 40-3, paragraph 2-24b.

PARENT SIGNATURE

DATE