UNITED STATES ARMY
CHILD & YOUTH SERVICES

PARENT CENTRAL USE ONLY:
Pass Registration Date: _____
Renew On: _____
Last Sports Physical: _____

CYS Program Registration Form

Sponsor Name: _____ Employer/Unit: _____

Rank: _____ ___MIL ___CIV ___CONT Work Phone: _____ Cell Phone: _____

Home Phone: _____ Email(s): _____

Address: _____
STREET CITY STATE ZIP

Spouse Name: _____ Employer/Unit: _____

Rank: _____ ___MIL ___CIV ___CONT Work Phone: _____ Cell Phone: _____

Home Phone: _____ Email(s): _____

Address: _____
STREET CITY STATE ZIP

Emergency Contact #1: _____ Phone: _____

Emergency Contact #2: _____ Phone: _____

Participant's Name: _____ Child's Age: _____ Date of Birth: _____

Current School Grade: _____ Ethnicity _____

Any physical conditions or allergies? _____

REFUND POLICY: No refunds unless program is canceled, participant moves out of state, or serious injury prevents participation, prior to start-up date.

WAIVER: I (parent/guardian) understand that in taking part in this program, there is a risk of injury, and that our participation assumes risk. I understand my child will not be covered by any program insurance and that in case of injury, I hold harmless the program, instructor, Child & Youth Services, and the U.S. Army for any injury while participating in the program.

PARENT/PARTICIPANT ACKNOWLEDGES AND AGREES TO THE FOLLOWING:

1. Be on time and prepared to start.
2. Be respectful and courteous to the instructor and other participants.
3. Do not disrupt the class by talking or misbehaving.
4. Pay attention and listen to the instructor at all times.
5. Practice safety and good sportsmanship at all times.

PARENT/PARTICIPANT CONSENT QUESTIONS:

1. My child's photograph can be released to media? **YES** or **NO**
2. My child can participate in on/off post excursions with CYS staff? **YES** or **NO**
3. My child can be transported in a government/commercial vehicle? **YES** or **NO**
4. My child can be transported in a private vehicle (only by emergency contact)? **YES** or **NO**

Signature: _____ Date: _____
Parent/guardian

Program Enrollment:

Program Enrolled In:	Date of Program:	Amount Paid:

Changes to Contact Information:

Sponsor Name: _____ Rank: _____ ___MIL ___CIV ___CONT

Employer/Unit: _____ Work Phone: _____

Cell Phone: _____Home Phone: _____

Email(s): _____

Address: _____
street city state zip

Spouse Name: _____ Rank: _____ ___MIL ___CIV ___CONT

Employer/Unit: _____ Work Phone: _____

Cell Phone: _____Home Phone: _____

Email(s): _____

Address: _____
street city state zip

Emergency Contact #1:_____ Phone: _____

Emergency Contact #2: _____ Phone: _____

Youth Sports Parent Agreement

The following agreement shall be followed by parents and children who are enrolled in Youth Sports. All parents must read and sign this agreement as an understanding of the rules and regulations put forth by the CYS Youth Program, the Youth Center, Volunteers, or other entities. By signing this agreement, you are stating that you understand and will abide by the rules and policies stated. The signing of this agreement is non-negotiable.

The following policies are policies set forth by the Youth Center:

- Parents must sign in/out of the Youth Center on the clipboard provided at the front desk.
- If child is enrolled in the afterschool program during the time of their activity, that child must be signed out to attend sports activity.
- Food and Drink will be consumed at the tables in the snack area of the youth center and not in gym area.
- There should be no food or drink in the parent waiting areas, dance room, tech lab, etc.
- Supervision of the child, siblings or other children who are/aren't participating in a Youth Sports program is the duty of the parent and parent alone.
  -Exceptions include children who are participating in a program sponsored by the Youth Center at the time of the Sports program.

The following policies are policies set forth by the Youth Sports program:

- All payments for the programs should be made at the time of registration.
- Registration for new or upcoming sessions must be done either online via Webtrac or in person at Central Registration. Registrations will not be taken via email or phone unless granted permission.
- Payments for sports can be made at Parent Central, any of the CDCs, the Youth Center, or online via Webtrac. Payment can be accepted via phone at any of the above stated locations with the preference being Parent Central.
- Youth Sports follows Harford County Public Schools school closings for Inclement Weather. Keep this in mind especially during winter months when schools may close for inclement weather. Youth Sports program will do its best to email/call/text a cancellation notice for programs. However, that is not always possible.

Parents Code of Ethics

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

- 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 wellbeing 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 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 of 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 adults.
- I will do my very best to make youth sports fun for my child.

- I will ask my child to treat other players, coaches, fans, and officials with respect regardless of race, sex, creed, or ability.
- 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 read the NYSCA National Standards for Youth Sports and do what I can to help all youth sports organizations implement and enforce them.

Child's Name (Print): _____ Sport_____

_____ _____

Parent Signature Date

Renewed Date:	Signature:

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CHILD, YOUTH, AND SCHOOL SERVICES HEALTH ASSESSMENT/SPORTS PHYSICAL
(AE Reg 608-10-1)

Data required by the Privacy Act of 1974

Authority: 10 USC 3013.
Purpose: (1) Verify child health and status of immunizations for admission requirements; (2) Note special program considerations or restriction on child participation; (3) Execute emergency medical procedures for chronic illness or conditions; (4) Refer the child for enrollment in Exceptional Family Member Program; (5) Certify the child is physically fit to participate in sports.
Routine use: In addition to those disclosures generally permitted under 5 USC 552a(b) of the Privacy Act, these records and information may specifically be disclosed outside DOD as a routine use pursuant to 5 USC 552a(b)(3) as follows: Information from this system may be disclosed to civilian health and welfare departments and agencies in emergency situations. The "Blanket Routine Uses" set forth at the beginning of the Army Compilation of Systems of Records Notices also apply.
Disclosure: Voluntary, but if information is not provided, individuals may not be able to participate in Child, Youth, and School Services activities.

Instructions: For health assessments, complete parts A and C; for sports physicals, complete parts A, B, and C.

Part A

Name of sponsor	**Home telephone**	**Work telephone**
	Cell phone	

Sponsor unit/work address	**Spouse's work telephone**

Child Health Information

Name of child	**Date of birth** (YYYYMMDD)	**Sex**
		☐ Male ☐ Female

Does your child have ongoing medical concerns? (If yes, explain circumstances and current status.)
☐ No ☐ Yes

Is your child enrolled in the Exceptional Family Member Program? (If yes, explain.)
☐ No ☐ Yes

Medical History

	Yes	No		Yes	No
1. ADD/ADHD	☐	☐	**15. Head injury or loss of consciousness**	☐	☐
2. Allergies to medicine, insect bites, or food	☐	☐	**16. Heart or blood pressure problems**	☐	☐
3. Any hospitalization or operation	☐	☐	**17. Heat stroke or exhaustion**	☐	☐
4. Asthma or difficulty breathing	☐	☐	**18. Joint injuries** (ankle/knee/wrist)	☐	☐
5. Autism spectrum disorder	☐	☐	**19. Learning problems**	☐	☐
6. Behavioral problems	☐	☐	**20. Neck or back injury**	☐	☐
7. Broken bones or sprains	☐	☐	**21. Required restricted physical activity**	☐	☐
8. Cancer	☐	☐	**22. Seizures or convulsions**	☐	☐
9. Chest pain with exercise	☐	☐	**23. Sleep problems**	☐	☐
10. Dental or orthodontic braces	☐	☐	**24. Speech or development delays**	☐	☐
11. Diabetes	☐	☐	**25. Vision problems** (glasses/contacts)	☐	☐
12. Dizziness or fainting with exercise	☐	☐	**26. Other** (list below)	☐	☐
13. Ear or hearing problems	☐	☐			
14. Headaches	☐	☐			

If you answered *yes* to any of the above, please explain:

Ongoing medications

Name	**Dosage**	**Frequency**

Allergies - All types (food, medicines, insect bites)

Type	**Reaction**	**Type**	**Reaction**

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Part B

Medical Staff Assessment (completed by licensed independent practitioner)

Age	Height	Weight
Yrs Mos	in/cm %	lb/kg %
BP /	Visual acuity (tested with/without glasses)	
P	Right /	Left /

	Normal	Abnormal	N/A	Comments
1. Eyes				
2. Ears, nose, and throat				
3. Hearing				
4. Mouth and teeth				
5. Neck (soft tissues)				
6. Cardiovascular				
7. Chest and lungs				
8. Abdomen				
9. Genitalia - hernia				
10. Skin and lymphatics				
11. Spine - scoliosis				
12. Extremities				
13. Neurological				
14. Wears braces/plates				

Based on this examination, the following abnormalities were found and may need treatment:

Immunizations are current and up to date ☐ Yes ☐ No

Participation recommended

☐ All sports ☐ Yes ☐ No ☐ Normal physical activity including physical education

☐ Additional comments ☐ 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 that could affect the child's participation in Child, Youth, and School Services programs (including sports).

Child/youth is able to participate in normal Child, Youth, and School Services programs: ☐ Yes ☐ No

Licensed healthcare professional stamp	Date	Licensed healthcare professional signature

Type or print name of parent or guardian	Date	Signature of parent or guardian

Health Assessment Annual Recertification

Health status changed	Date	Signature of parent or guardian
☐ Yes ☐ No		
Health status changed	**Date**	**Signature of parent or guardian**
☐ Yes ☐ No		

ARMY CHILD AND YOUTH SERVICES HEALTH SCREENING – TOOL #1

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.

SNAP Case Number: _____

FOR CER COMPLETION ONLY

☐ Initial Registration
Is child on waiting list? ☐ Yes ☐ No
Date care needed? _____
☐ Re-registration/Child Already in Program
☐ Change in Program

Date in from Patron:

Date out to APHN:

Part A – General Information

Child/Youth Name	Child/Youth School Grade (example: 3rd Grade)	Date of birth (YYYYMMDD)	Age

Type of Placement Requested: (check all that apply)
☐ Hourly Care ☐ Full Day Care ☐ Middle School/Teen Program ☐ Summer Camp ☐ Other: (specify)
☐ Part Day Care ☐ Before/After School Care ☐ SKIES/Instructional Classes ☐ Sports

Sponsor Name	Sponsor E-mail	Sponsor SSN

Spouse Name	Spouse E-mail

Home Phone	Cell Phone	Sponsor Unit

Home Address	Sponsor Duty Phone

Part B – Identification of Child/Youth Condition/Restrictions

Does you child have any of the following conditions/restrictions: (check no or yes and answer questions as appropriate)

1. Allergies
   a. Life threatening reaction? ☐ No ☐ Yes
   b. Rescue Medication (Epi-pen, Benadryl, Inhaler) ☐ No ☐ Yes
   c. Does child/youth need rescue inhaler? ☐ No ☐ Yes
   If your child/youth has an allergy, please list: _____
   Reaction: _____
2. Special Diet ☐ No ☐ Yes
   a. Is your child on a complex diet (i.e. gluten free, diabetic) ☐ No ☐ Yes
   b. Does your child have a food intolerance/mild food allergy (i.e. rash from strawberries/milk intolerance)? ☐ No ☐ Yes
   c. Does your child have a dietary religious restriction? ☐ No ☐ Yes
3. Asthma/Reactive Airway Disease/Breathing Problems? ☐ No ☐ Yes
   a. Does your child need a rescue med? ☐ No ☐ Yes
4. Does your child have diabetes? ☐ No ☐ Yes
5. Does your child have seizures? ☐ No ☐ Yes
6. Attention Deficit Disorder (ADD/ADHD)
   a. Are there behavior/conduct concerns while on meds? ☐ No ☐ Yes
   b. List ADD/ADHD medications: _____
7. Behavior/ conduct concerns (oppositional defiant disorder, anxiety, depression, bipolar, other)? ☐ No ☐ Yes
8. Autism Spectrum Disorders (Autism, Aspergers, Rett Syndrome, PDD-NOS) ☐ No ☐ Yes
9. Does your child have any of the following health concerns? (circle all that apply)- Hearing impairment, vision impairment other than corrective lenses, heart, kidney, physical disability SEVERE skin condition ☐ No ☐ Yes
   Please specify _____
10. Does your child have a speech/language and/or hearing loss that affects their ability to communicate their basic needs (hurt, bathroom, fear, thirst)? ☐ No ☐ Yes
    Explain: _____
11. Does your child have developmental delays other than MILD speech language/MILD hearing loss? ☐ No ☐ Yes
    Explain: _____
12. Are there any other conditions or concerns that you would Like staff to be aware of? ☐ No ☐ Yes
    Explain: _____

Part C – Medications

List any medications that are prescribed for your child/youth other than those listed above:

Will your child require medication administration during child care/youth supervision hours? ☐ No ☐ Yes

Part D – Early Intervention and Special Education

Does your child/youth receive special services/therapies? ☐ No ☐ Yes
Please specify: _____

Does your child/youth have an Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP) or 504 Plan? ☐ No ☐ Yes

Part E – Exceptional Family Member Program (EFMP) Enrollment

Is your child enrolled in the EFMP? ☐ No ☐ Yes If yes, specify for what condition: _____

_____ _____
Printed Name and Signature of Parent/Personal Representative of Child/Youth Date (YYYYMMDD)

If you have answered NO to all the questions above you are now finished with this form.
Please sign and date indicating that the information above is accurate and complete to the best of your knowledge.

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 please notify CYS Services immediately.

If you answered YES to any of the questions above, complete Part F on the next page.

Form Updated 11 Mar 09

Child/Youth Name	Date of birth (YYYYMMDD)	Age

Part F – Release of Information

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 SNAP 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 and Signature of Parent/Personal Representative of Child | Date (YYYYMMDD)

Part G – Army Public Health Nurse (APHN) Review

Current Medications other than those listed on page 1:

Diagnosis: _____

Background/Notes:

Medical Records Reviewed? ☐ No ☐ Yes ☐ Not Available

Training for CYS Staff/Provider Required:

Recommendation Summary:

SNAP REQUIRED: ☐ No SNAP required ☐ Modified ☐ Full ☐ Annual Review (No team meeting required)

Requirements Prior to Placement:

Medical Action Plan reviewed by APHN: ☐ Respiratory ☐ Allergy ☐ Seizure ☐ Diabetes ☐ Special Diet ☐ Other_____

APHN Printed Name or Stamp	APHN Signature	Date (YYYYMMDD)

Date Received by APHN	Date Returned to CER:

Form Updated: 11 Mar 09

Child's name: _____

Guardian: _____

MEMORANDUM FOR RECORD

SUBJECT: Child and Youth Services (CYS) 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 (for children in care only).
b. I acknowledge that CYS facilities are under video surveillance (for programs at CYSS facilities).
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.

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