



## ARMY CHILD, YOUTH & SCHOOL (CYS) SERVICES Parent Central Services Office Registration Checklist

Children/youth must be fully registered before they can use any CYS Services programs.  
 Contact your local Parent Central Services Office to set up an appointment to complete your registration.  
 Limited "walk-in" services may also be available.

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

**ITEMS / INFORMATION TO BRING TO YOUR REGISTRATION APPOINTMENT:**

Verification

- **Sponsor's Social Security Number** [Needed for Child Care Tax Credit, USDA funding, medical service identifier. Patron privacy is protected.] \_\_\_\_\_
- **Proof of Child Eligibility** (i.e. Legal Guardianship papers or Child Military ID Card) \_\_\_\_\_
- **Parent(s) Home and Work Information** (Need street address, mailing address [if different], military unit or employer name, primary/alternate phone numbers) \_\_\_\_\_
- **Email Addresses** (Need AKO email address and any private accounts you regularly check) \_\_\_\_\_
- **Proof of Parent(s) Income** (i.e. Leave & Earnings Statements / Pay Vouchers. If spouse is full time student, bring proof of school enrollment) (Needed to determine DOD Fee Category for child care/school age fees) \_\_\_\_\_
- **Local Emergency and Child Release Designees** (minimum of 2) (Need names/phone numbers we can contact or release your child to in an emergency situation if we are unable to reach you) \_\_\_\_\_
- **Family Care Plan Short-Term Release Designee** (Required for single/dual military and single/dual deployable civilian families) (Need name, address, phone numbers of designee) [Due within 30 days] \_\_\_\_\_
- **Child's Official Shot Record** \_\_\_\_\_
- **Deployment Orders** (Families of deployed individuals can obtain Army Family Covenant discounts and benefits with proof of deployment) \_\_\_\_\_

**FORMS COMPLETED BEFORE / DURING / AFTER YOUR VISIT:**

Verification

[Downloadable blank/fillable forms are available on line - click 'Forms/Links' in the menu bar]

- **Child Health Assessment** (CYSS Health Form Parts A, B & C {or Part A + School Physical}) [Due within 30 days] \_\_\_\_\_
- **Sports Physical** (CYSS Health Form Parts A,B & C) [Due before participation in all sports activities] \_\_\_\_\_
- **USDA Income Eligibility Form** (Allows us to receive additional funding to support meals/snacks provided) \_\_\_\_\_
- **DOD Child Care Fee Application** (To evaluate household income for eligibility for reduced fees) \_\_\_\_\_
- **Health Screening Tool** (To record/evaluate child's allergies, medical/physical conditions, etc.) \_\_\_\_\_
- **Medical Action Plan (MAP)** (Only needed if a child is diagnosed with allergies, diabetes, asthma/respiratory, or seizures that require staff to give rescue medication). [If recommended by Special Needs Assessment Team] \_\_\_\_\_

**ASK ABOUT SPECIFIC CYS SERVICES PROGRAMS AVAILABLE AT YOUR GARRISON - POSSIBILITIES INCLUDE:**

<ul style="list-style-type: none"> <li>- Full/Part Day Child Care</li> <li>- Part Day Preschool</li> <li>- Hourly Care</li> <li>- Before/After School Care</li> <li>- Kids on Site</li> </ul>	<ul style="list-style-type: none"> <li>- Vacation Camps</li> <li>- EDGE! Partnership Activities</li> <li>- imAlone</li> <li>- Home School Support</li> <li>- Strong Beginnings</li> </ul>	<ul style="list-style-type: none"> <li>- Middle School/Teen Activities</li> <li>- Youth Sports</li> <li>- SKIESUnlimited Classes</li> <li>- HIRED! Youth Apprenticeships</li> <li style="text-align: right; color: red;">- And More . . . . .</li> </ul>
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**Child Adult Care Food Program  
Income Eligibility Statement**

**PART I: Child or Adult enrolled to receive day care-**

<b>Name: (Last, First and Middle Initial)</b>	Food Stamp, TANF, or FDIPIR case number, Assistant Unit (AU), or Client ID number for <u>children only</u> . All the above, or SSI or Medicaid case number for <u>Adults</u> . Note: Do not use EBT numbers.	Head Start Participant
		<input type="checkbox"/>

**PART II: FOSTER CHILD:** If this is a foster child, check here . In certain cases, foster children are eligible for free and reduced-priced meals regardless of household income. If foster children live with you, please contact [ \_\_\_\_\_ ] at [ \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ ]. Skip to Part IV.

<b>PART III A:</b> <b>A. Name</b> (List everyone in household, including children)	<b>B. Gross income and how often it is received</b> Example: \$100/monthly, \$100/twice a month, \$100/every other week, \$100/weekly				<b>C. Check if NO Income</b>
	<b>1. Earnings from work before deductions</b>	<b>2. Welfare, child support, alimony</b>	<b>3. Social Security, pensions, retirement</b>	<b>4. All other income</b>	
1. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
2. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
3. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
4. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
5. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
6. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
7. _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>

**PART III-B: ENROLLMENT INFORMATION: Children Only**

My child is normally in attendance at the facility between the hours of \_\_\_\_\_ [am/pm] to \_\_\_\_\_ [am/pm] on the following days:

Check here if only before/after school care is provided.

(Circle all that apply). Sunday Monday Tuesday Wednesday Thursday Friday Saturday

My child will normally receive the following meals while in care:

(Circle all that apply): Breakfast AM Snack Lunch PM Snack Supper Evening Snack

**PART IV: Signature and Social Security Number (Adult must sign).**

An adult household member must sign this form. If Part III is completed the adult signing the form must also list his or her Social Security number or mark the "I don't have a Social Security Number" box. (See Privacy Act Statement on next page).

*I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.*

Signature: **X** \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State: GA Zip \_\_\_\_\_ Phone \_\_\_\_\_

Social Security Number \_\_\_\_\_  I do not have a Social Security Number

**PART V: Participant's ethnic and racial identities (optional)**

Mark one ethnic identity:

- Hispanic or Latino  
 Not Hispanic or Latino

Mark one or more racial identities:

- Asian  White  Black or African American  American Indian or Alaska Native  
 Native Hawaiian or other Pacific Islander

**Official Use Only: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12**

Total income: \_\_\_\_\_ Per:  Week  Every 2 weeks  Twice a month  Month  Year Household Size: \_\_\_\_\_

Categorical Eligibility: \_\_\_\_\_ Date withdrawn \_\_\_\_\_ Eligibility: Free \_\_\_\_\_ Reduced \_\_\_\_\_ Paid \_\_\_\_\_ Tier I \_\_\_\_\_ Tier II \_\_\_\_\_

Temporary: Free \_\_\_\_\_ Reduced \_\_\_\_\_ Time Period: \_\_\_\_\_ (expires after \_\_\_\_\_ days)

Determining Official's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Confirming Official's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Follow Up Official's Signature: \_\_\_\_\_ Date \_\_\_\_\_

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

Household Size	Yearly Income
1	
2	
3	
4	
5	
6	
7	
8	
Each additional person	Add:

**Privacy Act Statement:** The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the social security of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Food Stamp, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the Program.

**Non-discrimination Statement:** In accordance with Federal Law and I.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write to USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

## INSTRUCTIONS

### Households that receive Food Stamps, TANF, FDPIR, SSI or Medicaid: Complete the following:

**Part I:** For family day care home and child care center, list participant's name and a Food Stamp, TANF, or FDPIR case number. For adult day care, list participant's name and a Food Stamp, TANF, FDPIR, SSI or Medicaid case number.

**Part II:** Skip this part.

**Part III-A:** Skip this part.

**Part III-B:** Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.

**Part IV:** Sign the form. A Social Security Number is not necessary.

**Part V:** Answer this question if you choose to.

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### If you are applying on behalf of a Foster Child, complete a separate application for each foster child and complete the following:

**Part I:** For family day care home and child care center, list participant's name and a Food Stamp, TANF, or FDPIR case number. For adult day care, list participant's name and a Food Stamp, TANF, FDPIR, SSI or Medicaid case number.

**Part II:** Please contact us [phone number].

**Part III-A:** Skip this part.

**Part III-B:** Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.

**Part IV:** Sign the form. A Social Security Number is not necessary.

**Part V:** Answer this question if you choose to.

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### All other Households, including WIC households, complete the following:

**Part I:** For family day care home and child care center, list participant's name and a Food Stamp, TANF, or FDPIR case number. For adult day care, list participant's name and a Food Stamp, TANF, FDPIR, SSI or Medicaid case number.

**Part II:** Skip this part.

**Part III-A:** To report total household income from last month, complete the following:

**Column A-Name:** List the first and last name of each person living in your household as an economic unit. You must indicate yourself and all children living with you. In the case of an adult participant, the adult participant, and if residing with the adult participant, the spouse and dependent(s) of the adult participant. Attach another sheet if necessary.

**Column B-Gross Income last month and how often it was received:** Next to each person's name, list each type of income received last month, and how often it was received.

**Box 1:** List the gross income each person earned from work. This is not the same as take-home pay. Gross income is the amount earned before taxes and other deductions. The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly).

**Box 2:** List the amount each person got last month from welfare, child support, alimony.

**Box 3:** List Social Security, pensions, and retirement.

**Box 4:** List all other income sources including Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits IVA benefits), disability benefits, regular contributions from people who do not live in your household. Report net income from self-owned business, farm, or rental income. Next to the amount, write how often the person got it. If you are in the Military Housing Privatization Initiative do not include this housing allowance.

**Column C-Check if no income:** If the person does not have any income, check the box.

**Part III-B:** Child care centers only. Provide the normal days and hours your child is in attendance in the center and indicate the meals he/she normally receives while in care.

**Part IV:** An adult household member must sign the form, and list his/her social security number. Or, mark the box if he/she does not have one.

**Part V:** Answer this question if you choose to.

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**Privacy Act Statement:** This explains how we use the information you give us.

SHARING INFORMATION WITH MEDICAID/SCHIP

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Dear Parent/Guardian:

If your children qualify for free or reduced price meals, they may also be able to get free or low cost health insurance through Medicaid or the State Children's Health Insurance Program (SCHIP). Children with health insurance are more likely to get regular health care and are less likely to become sick.

Because health insurance is so important to children's well-being, the law allows us to tell Medicaid and SCHIP that your children are eligible for free or reduced price meals, *unless you tell us not to*. Medicaid and SCHIP only use the information to identify children who may be eligible for their programs. Program officials may contact you to offer to enroll your children in this health insurance program. Filling out the CACFP Meal Benefit Income Eligibility Forms does not automatically enroll your children in health insurance.

If you do not want us to share your information with Medicaid or SCHIP, fill out the form below and send it with your Income Eligibility Form to [address] by [date]. (Sending in this form will not change whether your children get free or reduced price meals.).

- No! I DO NOT want information from my CACFP Meal Benefit Income Eligibility Form shared with Medicaid or the State Children's Health Insurance Program.

If you checked no, fill out the form below.

Child's Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Print Your Name: \_\_\_\_\_

Address: \_\_\_\_\_

For more information, you may call \_\_\_\_\_ at \_\_\_\_\_

# The Child and Adult Care Food Program

## Income Eligibility Statement Form and Supporting Documents

The United States Department of Agriculture (USDA) issued revised Income Eligibility Statements (IES) and other required forms to all state agencies to disseminate to institutions participating in the Child and Adult Care Food Program (CACFP). The newly revised IES package includes the following: IES form and instructions, reduced income guidelines template with privacy and non-discrimination statement, Sharing Information with Medicaid/SCHIP letter, sample house-hold letters based on program type, and template letters to use when verifying income and reporting the results of the verification.

Bright from the Start issued the new IES package and supporting documents to all institutions via email and uploaded the package the website. Effective March 1, 2009, participating institutions were instructed to begin using the revised forms for newly enrolled children/adults with the understanding that the form must be implemented by October 1, 2009 for all children/adults and obtained annually thereafter.

### Frequently Asked Questions

#### **Q. What information do I issue to parents?**

**A.** Institutions and facilities should issue the IES form, reduced income guidelines with the privacy and non-discrimination statement, appropriate household letter, and the Sharing Information with Medicaid/SCHIP letter to parents/guardians of children/adults participating in the CACFP.

#### **Q. Why is it necessary to issue the Sharing Information with Medicaid/SCHIP letter to parents?**

**A.** Parents/guardians that do not wish to have their information shared with either Medicaid or SCHIP must complete the form and return to facility. Otherwise and when requested by Bright from the Start or the United States Department of Agriculture (USDA), parent/guardian information will be shared with Medicaid/SCHIP.

#### **Q. Is it necessary to have three official's signatures on the new IES form-especially when the center is an independent center with only one staff person managing the CACFP?**

**A.** No. Only one signature is required for Independent centers with only one staff person responsible for managing the CACFP. However, institutions with more than one person managing the CACFP, and center and administrative sponsors are required to have a minimum of two signatures: determining official and confirming official.

#### **Q. What is the purpose of having a determining and confirming official signature?**

**A.** The confirming official will review the form and ensure accuracy and completeness.

**Q. Do I send a report to Bright from the Start listing parent/guardians that want their information shared with Medicaid/SCHIP?**

**A.** No. When instructed by USDA, Bright from the Start will request and collect data from institutions.

**Q. Can this form be used for children in childcare facilities and adults in adult daycare facilities?**

**A.** Yes.

**Q. Can siblings be listed on one form?**

**A.** Yes. Siblings from the same household can be listed on one form as long as there is space available.

**Q. When do I verify parent/guardian income?**

**A.** At the request of the United States Department of Agriculture (USDA), Bright from the Start, or any of its agents.

**Q. Where can I get copies of the IES form and supporting documents?**

**A.** Access Bright from the Start's webpage at [www.decal.ga.gov/Nutrition/NutritionServices.aspx](http://www.decal.ga.gov/Nutrition/NutritionServices.aspx)

**Q. Can I still participate in the CACFP if parents do not complete the IES form or do not return the form to my center?**

**A.** Yes. However, children that do not have IES forms on file must be placed in the "**paid**" category on the roster, which will effect monthly reimbursement.

# 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.

**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. Spouse name		
8. Home phone	9. Duty phone	10. 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)

**HEALTH ASSESSMENT/SPORTS PHYSICAL STATEMENT (HASPS)  
for CYS SERVICES  
ENROLLMENT, 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

<b>PART B: Physical Exam</b>				
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:	/	Visual Acuity Right / Left /	Tested with / without glasses	
P:				
	<b>NORMAL</b>	<b>ABNORMAL</b>	<b>N / A</b>	<b>COMMENTS</b>
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"/> Additional comments:		<input type="checkbox"/> Restrictions:		

Sports Physical is valid for 1 year from date indicated below

<b>PART C</b>		
<b>Special Medical Considerations:</b> 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	