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	Best Contact Number
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 ☐ No ☐ Yes
   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) ☐ No ☐ Yes
   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.

Child/Youth Name	Date of birth (YYYYMMDD)	Age

Part F – Release of Information

I authorize ______WACH______(name of Medical Treatment Facility or physician's practice) to release any medical information regarding my child ____________________(name of child) to the ______Fort Irwin______ (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: