

Welcome to Child, Youth and School Services, Fort Gordon. To make your registration process easier, please have the following required documents with you at the time of your registration:

- Proof of eligibility (Military or Civilian ID Card, Legal Documentation of Guardianship)**
Children/youth eligible to use CYSS services are those under the legal guardianship of active duty military personnel, Appropriate Fund (APF) and Nonappropriated Fund (NAF), Department of Defense (DoD) civilians, reservist on active duty, or during inactive personnel training, DoD contractors, and military retirees.
- Proof of immunizations (children/youth up to age 13)**
- Childs Social Security Card**
- Birth Certificate or Passport or DoD dependant ID card**
- LES or Pay voucher for both Parents (for fulltime child care or before and afterschool care)**
- The Names and Phone Numbers of at least two emergency contacts. (One must be local and able to pick up in an emergency) Three emergency contacts must be on file within 30 days of registration.**

At the time of your registration you will be asked to complete with signature:

- DoD form 2652, *Application for DoD Child Care Fees***
- USDA CACFP Enrollment Form**
- DA FORM 7625-1, *Special Needs Form***

Within 30 days of registration you will need to bring to Central Registration or your CYSS Facility:

- Health Assessment / Sport Physical Form**
*Health Assessment can be updated at re-registration for a total of three years – **Sport Physical MUST be completed annually and turned at time of registration for sports. Sports registrations require proof of age (birth certificate or Military ID card)***
- Single and Dual Military must have a Family Care Plan (DA Form 5305-R) turned into CER or facility with the designated short term care provider listed in CYMS.**

For Re-Registration please bring for review shot records, current LES or pay stubs, review Health Certificate, new signatures required on Special Needs Form (if applicable), USDA and DoD Fee form.

New Registration

Re-Registration

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)
3. Family member prefix		
4. Type of placement requested		5. Date (YYYYMMDD)
6. Sponsor name		7. SSN (last four digits)
8. 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)

7625-1 sent by CER Clerk _____ on ____ / ____ / ____

Follow up / registration completed on ____ / ____ / ____

Child's Name:

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)

Child's Name:

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)

Nutrition Program Facts Food and Nutrition Service



I do/ do not participate in the WIC Program.

Child's Name _____

Parent's Signature _____ Date _____

WIC: The Special Supplemental Nutrition Program for Women, Infants and Children

1. What is WIC?

WIC provides nutritious foods, nutrition education, and referrals to health and other social services to participants at no charge. WIC serves low-income pregnant, postpartum and breastfeeding women, and infants and children up to age 5 who are at nutrition risk.

WIC is not an entitlement program; that is, Congress does not set aside funds to allow every eligible individual to participate in the program. Instead, WIC is a Federal grant program for which Congress authorizes a specific amount of funding each year for program operations. The Food and Nutrition Service, which administers the program at the Federal level, provides these funds to WIC State agencies (State health departments or comparable agencies) to pay for WIC foods, nutrition education, and administrative costs.

2. Where is WIC available?

The program is available in all 50 States, 34 Indian Tribal Organizations, America Samoa, District of Columbia, Guam, Commonwealth Islands of the Northern Marianas, Puerto Rico, and the Virgin Islands. These 90 WIC State agencies administer the program through 2,200 local agencies and 9,000 clinic sites.

3. Who is eligible?

Pregnant or postpartum women, infants, and children up to age 5 are eligible. They must meet income guidelines, a State residency requirement, and be individually determined to be at "nutrition risk" by a health professional.

To be eligible on the basis of income, applicants' income must fall at or below 185 percent of the U.S. Poverty Income Guidelines (currently \$35,798 for a family of four). A person who participates or has family members who participate in certain other benefit programs, such as the Food Stamp Program, Medicaid, or Temporary Assistance for Needy Families, automatically meets the income eligibility requirement.

4. What is "nutrition risk?"

Two major types of nutrition risk are recognized for WIC eligibility:

- Medically-based risks such as anemia, underweight, overweight, history of pregnancy complications, or poor pregnancy outcomes.
- Dietary risks, such as failure to meet the dietary guidelines or inappropriate nutrition practices.

Nutrition risk is determined by a health professional such as a physician, nutritionist, or nurse, and is based on Federal guidelines. This health screening is free to program applicants.