Parent Central Services Registration Checklist
Child Development Center

Phone: 717.245.3801

459 Bouquet Road

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 TO BRING TO REGISTRATION APPOINTMENT	VERIFICATION
Sponsor's Social Security Number (Needed for Child Care Tax Credit, USDA funding. Patron Privacy is protected)	
Proof of Child Eligibility (i.e. Legal Guardianship, DEERS Enrollment, Child Military ID Card, or Birth Certificate along with Marriage Certificate,)	
Parent(s) Home and Work Information (street/mailing address [if different],military unit or employer name, primary/alternate phone numbers)	
Email Addresses (Need Enterprise work email and any private accounts you check regularly)	
Proof of Parent(s) Income (i.e. Leave and Earnings Statement/Pay Vouchers. If spouse is a full time student, proof of enrollment is needed. Determination of DOD Fee Category for child care/school age fees is based on Total Family Income) 3 consecutive paystubs needed, unless ACTIVE DUTY	
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, unless enrolled in PUBLIC SCHOOL)	
Deployment Orders (Families of deployed individuals can obtain discounts and benefits with proof of deployment US ARMY)	

FORMS COMPLETED BEFORE/DURING/AFTER YOUR VISIT	VERIFICATION
Child Health Assessment/Sports Physical Form (due within 30 days of your registration appointment for children birth through 5th grade) (Sports physical portion is valid for one year and due before participation in any sports activities for all ages. Sports Physical must be valid through sport season)	
Health Screening Tool-1 (To record/evaluate child's allergies, medical/physical conditions, etc. for all children birth through 5th 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)	
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)	
DOD Child Care Fee Application (To evaluate household income for reduced fee eligibility)	

Ask About Specific CYSS Programs. Here are Just A Few!

Full/Part Day Care **Part Day Preschool** **Strong Beginnings**

Hourly Care **Before/After School Care** **Middle School Teen**

Sports **SKIES**

U.S. Army Child, Youth
& School Services

CHILD DEVELOPMENT SERVICE (CDS) SPONSOR/PROGRAM AGREEMENT

For use of this form, see AR 608-10; the proponent agency is DCS, G-1.

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, United States Code, Section 3013

PRINCIPAL PURPOSE: Information is used by DA personnel and patrons to: (1) Identify and clarify responsibilities of all parties involved in agreement, (2) specify commitment regarding acceptance and provision of CDS services.

ROUTINE USES: Information provided may be released IAW the Army's blanket routine uses contained in AR 340-21.

DISCLOSURE: Disclosure of requested information is voluntary; however, if information is not provided, individuals may not be able to participate in CDS programs.

NAME OF SPONSOR *(Last, first, MI)*

PROGRAM
Carlisle CDC

VALID FROM *(Month, day, year to month, day, year)*

SERVICE *(Check appropriate box)*

☐ FULL DAY ☐ PART DAY PRESCHOOL ☐ PART DAY SCHOOL AGE ☐ FCC HOME ☐ HOURLY

AGE GROUP CATEGORY *(Check appropriate box)*

☐ INFANT ☐ TODDLER ☐ PRESCHOOL AGE ☐ SCHOOL AGE

I agree to enroll my child/children _____

in the Moore Child Development Center

CDS Facility/Family Child Care Home located at

455 Fletcher Road Carlisle Barracks, PA 17013

PROGRAM SERVICES

PROGRAM OPERATING HOURS ARE AS FOLLOWS (List hours) (CDS personnel)

MON 615 TO 1730 TUES 615 TO 1730 WED 615 TO 1730

THURS 615 TO 1730 FRI 615 TO 1730 SAT _____ TO _____

SUN _____ TO _____

*SERVICES FOR MY CHILD/CHILDREN WILL BE AS FOLLOWS (List hours) (Sponsor)

MON _____ TO _____ TUES _____ TO _____ WED _____ TO _____

THURS _____ TO _____ FRI _____ TO _____ SAT _____ TO _____

SUN _____ TO _____

SERVICES WILL NOT BE AVAILABLE ON *(List time/date) (CDS personnel)*

* Authorized Closures (no fee adjustment) I WILL BE NOTIFIED IN ADVANCE, WHENEVER POSSIBLE, OF ADDITIONAL PERIODS OF NON-SERVICE AS DETERMINED BY CDS PERSONNEL.

(CHILD MAY BE DENIED CARE WHEN ILLNESS PRECLUDES PARTICIPATION IN ROUTINE PROGRAM ACTIVITIES)

PRIOR NOTICE REQUIREMENT *(List amount of time required to terminate services) (CDS Personnel)*

Failure to provide two weeks advance notice for withdrawal will result in a two week minimum charge to the household. Withdrawal forms are available at the front desk.

UNIQUE CONSIDERATIONS *(Sponsor)*

I REQUEST THE FOLLOWING SPECIAL NEEDS OF MY CHILD/CHILDREN AS ACCOMMODATED

MY CHILD/CHILDREN REQUIRES THE FOLLOWING SPECIAL ITEMS WHICH I WILL SUPPLY

- Acceptable Footware (closed toed and closed back shoes)
- Spare set of clothes daily
- Needed hygiene items (diapers/wipes/creams)

*NON APPLICABLE FOR HOURLY SERVICES

FEES AND CHARGES *(CDS Personnel)*

RATES FOR PROGRAM SERVICES ARE AS FOLLOWS:

Fee Category:_____ Bi-Monthly Tuition:_____ or Monthly Tuition:_____

Part Day Tuition:_____ Hourly: $4 hour up to 20 hours a week on space available basis.

I understand that I am choosing not to provide my Pay/LES and understand I will be placed in CAT9. _____

MISCELLANEOUS FEES FOR PROGRAM SERVICES ARE AS FOLLOWS:

Late fee payments are $10.00 per child for mi-monthly (Full Day) and a one time late fee of $20.00 for monthly (Part Day). These fees will be assessed on the 6th business day. Late Pick-up Fees are $1.00 per minute for the first 15 minutes, then $5.00 for the next 45 minutes. Lat epickup fees are accessed per site. Return Check Fee is $25.00

AN OVERTIME/LATE FEE OF $ 1.00 per minute WILL BE CHARGED STARTING AT 1730 HOURS.

*PAYMENT OBLIGATION IS BASED ON HOURS I AGREE TO USE SERVICES NOT ON ACTUAL HOURS OF CHILD ATTENDANCE, UNLESS THEY EXCEED THE HOURS CONTRACTED.

*IN THE EVENT OF ABSENCE OF MY CHILD/CHILDREN FROM CARE DUE TO ILLNESS, FEES WILL/WILL NOT BE REDUCED.

*IN THE EVENT OF ABSENCE OF MY CHILD/CHILDREN FROM CARE DUE TO VACATION, FEES WILL/WILL NOT BE REDUCED.

FEES WILL BE PAID IN THE FOLLOWING MANNER

Hourly Care fees will be paid daily upon pickup.

Part Day Preschool/ Pre-Kindergarten fees will be paid monthly in advance.

Full Day fees will be paid bi-monthly or monthly in advance.

Note: Full Day fees include 10 days of Non-Paid Child Care Leave

FEES AND CHARGES ARE SUBJECT TO CHANGE. PATRONS WILL BE NOTIFIED OF CHANGES 30 DAYS PRIOR TO EFFECTIVE DATE.

POLICIES *(CDS Personnel)*

*CHILD MEDICATION WILL BE ADMINISTERED ONLY UPON MY WRITTEN REQUEST UNDER THE FOLLOWING CDS CONDITIONS

Medication administrative is authorized in Full Day care only. Medication must be prescribed. Physician or parents must administer first dose. Children will be on oral medication 24 hours before dosage is administered by CDS Personnel. DA Form 5225-R (CDC Medical Dispensation Record) must be completed prior to administration of medication. Parents may administer physician prescribed medication to their children in the CDC. Only physician prescribed medications is permitted within CDC Programs.

LAUNDERING CHILD'S/CHILDREN'S SOILED CLOTHING WILL/WILL NOT BE DONE ON A ROUTINE BASIS.

I WILL PROVIDE THE FOLLOWING TO MEET CDS PROGRAM REQUIREMENTS

CDC Requirements:

- Provide daily telephone numbers for emergency notification.
- Provide Health Assessment within 30 days of registration
- Provide Family Care Plan within 30 days of registration (Single/Dual Military)
- Provide Notification of Immunizations

I ACKNOWLEDGE A SHARED RESPONSIBILITY WITH CDS FOR CHILD ABUSE PREVENTION

Child abuse if a shared responsibility of parents and CDC staff. We will work cooperatively to keep each other informed on a daily basis and maintain open communication of behalf of the child's health and welfare. CDS has an open door policy and welcomes visits by parents. IAW AR 608-10, Para 2-20 and AR 608-18, all CDS employees are mandated to report ALL suspected child abuse.

I ACKNOWLEDGE AND CONSENT TO THE FOLLOWING CDS POLICIES CONCERNING THE CARE OF MY CHILD

A parent handbook is provided. Parents must ensure the understanding and compliance with policies and procedures. As changes occur, your will be given updated statements. Parents will be notified daily of any unusual occurrences concerning their children.

Children are accepted on a trial basis for a period not to exceed 30 days from the first date of attendance. If. at anytime during that period, it is determined by CDS that the child's needs cannot be accommodated in the CDS delivery systems, the Outreach Services Director will assist in referral.

*All CDS programs closures correspond with the direction and guidance from the Garrison Commander's Office. For 24 hour status updates on closures please call 717-245-3700. Fee adjustments will NOT be made due to holidays, closures, or delays.

SIGNATURE OF SPONSOR	DATE
SIGNATURE OF CDS REPRESENTATIVE OR FCC PROVIDER	DATE

Army Child, Youth and School Services (CYSS)

Program Information Form

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, United States Code, Section 3012. **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**: 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's Name: _____ Grade/ Rank: _____

Status: Active Duty Guard Reserve DoD Civilian Eligible Contractor IF Student

Branch of Service: Army Air Force Navy Marine Corps Coast Guard

Installation Assigned (i.e. Carlisle Barracks, Letterkenny): _____

Employer: _____ Work Phone: _____

Home Address: _____ City,State,Zip: _____

Home Phone: _____ Cell Phone: _____ Live On-Post? ☐ Yes ☐ No

Sponsor's Email Address (AKO Preferred): _____

Spouse/Other Adult Contributor Name: _____ Grade/Rank:_____

Status: Active Duty Guard Reserve DoD Civilian Eligible Contractor Stay at Home Parent

Branch of Service: Army Air Force Navy Marine Corps Coast Guard

Employer: _____ Work Phone: _____

Cell Phone: _____ Spouse's/Alternate Email _____

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

Emergency Contacts

(We need three local contacts, other than sponsor or spouse, authorized to respond in an emergency)

Name:_____ Home:_____Cell:_____ Work:_____
Can your child/children be picked up by this person? ☐ Yes or ☐ No

Name:_____ Home:_____ Cell:_____ Work:_____
Can your child/children be picked up by this person? ☐ Yes or ☐ No

Name:_____ Home:_____ Cell:_____ Work:_____
Can your child/children be picked up by this person? ☐ Yes or ☐ No

5.A.01 Emergency Contacts

U.S. Army Child, Youth
& School Services

Current Health Insurance Information

Sponsor's Name:_____

Name of Insurance Company: _____

Policy Number:_____

☐ No Insurance

☐ Parent/Sponsor does not wish to provide insurance information

Signature of Parent/Sponsor

U.S. Army Child, Youth
& School Services

CHILD DEVELOPMENT SERVICES *(CDS)* CHILD AND FAMILY PROFILE

For use of this form, see AR 608-10; the proponent agency is DCSPER

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY:	Title 10, United States Code, Section 3013
PRINCIPAL PURPOSE:	Information is used by DA personnel to: (1) develop programs meeting needs of child and family, (2) ensure appropriate placement of child, (3) identify contingency plan for child illness, (4) verify Family Care Plan, and (5) identification of potential program volunteers.
ROUTINE USES:	Information provided may be released IAW the Army's blanket routine uses contained in AR 340-21.
DISCLOSURE:	Disclosure of requested information is voluntary; however, if information is not provided, individuals may not be able to participate in CDS programs.

NAME OF SPONSOR *(Last, first, MI)*	DATE
ADDRESS *(Include ZIP Code)*	TELEPHONE
DUTY ADDRESS *(Include ZIP Code)*	TELEPHONE

CHILD DATA

NAME *(Last, first, MI)*	NICKNAME	BIRTH DATE

DEVELOPMENTAL TASKS/ACCOMPLISHMENTS FOR INFANTS AND TODDLERS *(Check appropriate blocks)*

SITS	☐ WITH SUPPORT	☐ INDEPENDENTLY		
WALKS	☐ WITH SUPPORT	☐ INDEPENDENTLY		
SPEECH	☐ SINGLE WORDS	☐ PHRASES	☐ SENTENCES	
TOILET TRAINED	☐ DAY	☐ NIGHT		
SELF-HELP SKILLS	☐ FEEDS	☐ TOILETS	☐ DRESSES	
	☐ TIES	☐ ZIPS	☐ BUTTONS/SNAPS	
READINESS SKILLS	☐ COLORS	☐ PRINTS NAME	☐ CUTS	
ATTENTION SPAN	☐ SPORADIC	☐ MODERATE	☐ SUSTAINED	
ACTIVITY LEVEL	☐ LOW	☐ MODERATE	☐ HIGH	
PLAYS	☐ ALONE	☐ NEAR OTHERS	☐ WITH OTHERS	

INFANTS/TODDLER UNIQUE VOCABULARY *(List child's special words and what they actually mean)*

CHILD'S WORDS	MEANING	CHILD'S WORDS	MEANING
	DRINK		
	BATHROOM		
	BOWEL MOVEMENT		
	URINATION		
	SPECIAL TOY*(S)*.		

CHILD'S PREFERENCES

FOODS	TOYS	PASTIMES

SPECIAL CONSIDERATIONS

FEARS/DISLIKES	PERSONALITY CHARACTERISTICS	SPECIAL NEEDS

PREVIOUS GROUP EXPERIENCES	RESPONSE TO NEW/STRANGE SITUATION
NAP *(Comments)* ☐ YES ☐ NO	BEDTIME *(Time, etc.)*

FAMILY DATA

HOUSEHOLD MEMBERS			PETS	
NAME	AGE	RELATIONSHIP TO CHILD	TYPE	NAME

REASONS(s) FOR USE OF CDS PROGRAM*(s)*

CONTINGENCY CARE PLAN FOR CHILD ILLNESS

CAR POOL/TRANSPORTATION ARRANGEMENTS

FAMILY CARE PLAN *(Sole Parent/Dual Sponsors)*

VOLUNTEER AVAILABILITY *(Check appropriate blocks)*

☐ FIELD TRIPS AIDE ☐ HOLIDAY ACTIVITIES

☐ AT HOME PROJECTS ☐ ON SITE ADMINISTRATIVE/CURRICULUM PROJECTS

☐ TOY/EQUIPMENT REPAIR ☐ CLASSROOM AIDE

OTHER

EMERGENCY NOTIFICATION DESIGNEE	HOME PHONE	DUTY PHONE	CHILD RELEASE DESIGNEE
EMERGENCY NOTIFICATION DESIGNEE	HOME PHONE	DUTY PHONE	CHILD RELEASE DESIGNEE
EMERGENCY NOTIFICATION DESIGNEE	HOME PHONE	DUTY PHONE	CHILD RELEASE DESIGNEE

REMARKS

CHILD AND YOUTH SERVICES HEALTH ASSESSMENT / SPORTS PHYSICAL

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: Health Assessment complete sections A & C; Sports Physicals complete sections A, B & C.

PART A

Name of Sponsor	Home Telephone Cell Telephone	Duty/Work Telephone
Sponsor Unit / Work Address	Sponsor SSN XXX-XX-XXXX	Spouse's Work Telephone

CHILD HEALTH INFORMATION

Name of Child	Birth Date	Sex ☐ Male ☐ Female

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. Other problems (list below)		
13. Chest pain with exercise					

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

PART B: SPORTS PHYSICAL

Medical Staff Assessment (Completed by licensed independent practitioner)

Age YRS MOS	**Height** _____ cm. (_____ %ile)	**Weight** _____ kgs. (_____ %ile)
BP: / **P:**	**Visual Acuity** Right / Left / Tested with / without glasses	

	NORMAL	ABNORMAL	N / A	COMMENTS
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: ☐ Yes ☐ No

PARTICIPATION RECOMMENDATIONS

☐ All sports _____Yes _____ No ☐ Normal physical activity to including PE

☐ PA 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 which the child requires in order to participate in CYS programs (to include Sports).

Child / Youth is able to participate in normal CYS programs? ☐ Yes ☐ No

Date	**Licensed Health Care Professional Stamp**	**Licensed Health Care Professional Signature**

Date	**Type or print name of Parent or Guardian**	**Signature of Parent or Guardian**

Health Assessment Re-Certification

Date	**Health Status Changed**	**Signature of Parent or Guardian**
	☐ Yes ☐ No	
Date	**Health Status Changed**	**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? ☐ No ☐ Yes
   (circle all that apply)- Hearing impairment, vision impairment other than corrective lenses, heart, kidney, physical disability
   SEVERE skin condition
   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 and Adult Care Food Program
Child Enrollment Form

Sponsor:_____
Center:_____

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE (SAMPLE)

This document does not have to be completed for children in Emergency Shelters, Outside School Hours, and/or At-Risk programs. It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Eligibility Application renewal period. Review completed enrollment form and enter the effective date in lower right hand section.

PARENTS: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year thereafter. This information will help ensure all children receive appropriate meals during their care.

Please complete all areas to include signing and dating same.

FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIRST CHILD	☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
NAME		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
BIRTH DATE		Other:								
AGE		**Enrollment Date:** **Withdrawal Date:**								
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		☐ *Same Times as Above*								
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
SECOND CHILD	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
NAME		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
BIRTH DATE		Other:								
AGE		**Enrollment Date:** **Withdrawal Date:**								
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		☐ *Same Times as Above*								
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
THIRD CHILD	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
NAME		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
BIRTH DATE		Other:								
AGE		**Enrollment Date:** **Withdrawal Date:**								
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		☐ *Same Times as Above*								
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FOURTH CHILD	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
NAME		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
BIRTH DATE		Other:								
AGE		**Enrollment Date:** **Withdrawal Date:**								
FULL NAME OF ENROLLED CHILD (Include Birth Date/Age	DAYS OF WEEK IN ATTENDANCE	TIMES CHILD NORMALLY ATTENDS DURING WEEK								MEALS RECEIVED
		TIME-IN			TIME OUT			TIME CHILD ATTENDS SCHOOL		
		☐ *Same Times as Above*								
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
FIFTH CHILD	☐ *Same as Above* ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐ SATURDAY ☐ SUNDAY									☐ *Same Meals as Above* ☐ BREAKFAST ☐ A.M. SNACK ☐ LUNCH ☐ P.M. SNACK ☐ SUPPER ☐ EVENING SNACK
NAME		☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
BIRTH DATE		Other:								
AGE		**Enrollment Date:** **Withdrawal Date:**								

Signature _____ _____ _____

Signature of Parent or Guardian *Date* *Telephone Number of Parent or Guardian*

CHILD CARE REPRESENTATIVE USE ONLY: _____ _____

Name of Representative/Signature *Date*

The effective date can be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month this form is received.

This portion of the form can be used to capture multi-year annual updates.

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Annual Time Period Covered by Signature: ____________________ **to** ____________________

Signature Parent/Guardian____ **Date** ____________________

Signature Center Administrator/Home Provider____________________________ **Date** ____________________

****
****

Annual Time Period Covered by Signature: ____________________ **to** ____________________

Signature Parent/Guardian____ **Date** ____________________

Signature Center Administrator/Home Provider____________________________ **Date** ____________________

****
****

Annual Time Period Covered by Signature: ____________________ **to** ____________________

Signature Parent/Guardian____ **Date** ____________________

Signature Center Administrator/Home Provider____________________________ **Date** ____________________

****
****

Annual Time Period Covered by Signature: ____________________ **to** ____________________

Signature Parent/Guardian____ **Date** ____________________

Signature Center Administrator/Home Provider____________________________ **Date** ____________________

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Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800)877-8339; or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer.

Child and Adult Care Food Program
Child Care Center Meal Benefit Income Eligibility Form

Part 1. All Household Members

Names of Enrolled Child(ren) (First, Middle Initial, Last)	Check if a foster child (the legal responsibility of a welfare agency or court) * If all children Listed below are foster children, skip to Part 5 to sign this form.	Check if NO income
	☐	☐
	☐	☐
	☐	☐
Names of all Household Members (First, Middle Initial, Last)		
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household received [State SNAP], [FDPIR], or [State TANF cash assistance], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**
NAME:_____ CASE NUMBER: ___ ___ - ___ ___ ___ ___ ___ ___ ___

Part 3. If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call **[Your center director, Homeless Liaison, Migrant Coordinator at Phone #]** Homeless ❑ Migrant ❑ Runaway❑

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** household members with income)	**B. Gross income and how often it was received**			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All Other Income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$_____/_____
	$_____/N/A	$_____/N/A	$_____/N/A	$_____/N/A
	$_____/N/A	$_____/N/A	$_____/N/A	$_____/N/A
	$_____/N/A	$_____/N/A	$_____/N/A	$_____/N/A
	$_____/N/A	$_____/N/A	$_____/N/A	$_____/N/A
	$_____/N/A	$_____/N/A	$_____/N/A	$_____/N/A

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement on the back of this 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 purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign Here: _____ Print Name: _____ Date: _____

Address: _____ City:_____ State: _____ Zip Code: _____

Phone Number: _____

Last four digits of Social Security Number: _*_*_*-_*_*-____ ❑ I do not have a Social Security Number

Part 6. 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

Don't fill out this part. This is for 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: _____ Eligibility: Free_____ Reduced_____ Denied (Paid)_____ Date Withdrawn: _____

Reason for Denied: _____

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
1	$20,665
2	$27,991
3	$35,317
4	$42,643
5	$49,969
6	$57,295
7	$64,621
8	$71,947
Each additional person:	+$7,326

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 the participant for free or reduced price meals. You must include the last four digits of the Social Security Number 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 Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for the participant 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 the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: This explains what to do if you believe you have been treated unfairly. "In accordance with Federal Law and U.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 USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer."