# U.S. Marine Corps Children, Youth & Teen Programs Registration Form

Date:

**Privacy Act Statement:**

**AUTHORITY:** 10 U.S.C. § 5013; 10 U.S.C. § 5041; and Marine Corps Order P1710.30E.
**PRINCIPAL PURPOSE:** This System of Records is governed by Privacy Act System of Records Notice NM01754-3 which can be downloaded at http://dpclo.defense.gov/privacy/SORNs/component/navy/NM01754-3.html. Information provided is used by USMC personnel to obtain information on authorized Children, Youth and Teens Program (CYTP) patrons for purposes of registration, and parent/guardian and emergency contacts.
**RETENTION AND SAFEGUARDING:** The information collected in this System will be maintained in paper and networked databases using password controlled systems and access to files based on a predefined need to know. Records are kept for two years after individual is no longer in CYTP and then destroyed by authorized disposal.
**ROUTINE USES:** In addition to those disclosures generally permitted under the Privacy Act of 1974, to various officials outside the Department of Defense (DoD) specifically identified in Privacy Act System of Records notice NM01754-3, and pursuant to the blanket routine uses established by DoD that apply to all DoD Privacy Act Systems of Records and posted at http://privacy.defense.gov/blanket_uses.shtml.
**DISCLOSURE:** Information is voluntary; however, if information is not provided, individuals may not be able to participate in CYTP activities.

| | | |
|---|---|---|
| Sponsor First Name: | Command/Unit/Employer: | |
| Sponsor Last Name: | Wk Ph: | Extension: |
| Address 1: | Email: | |
| Address 2: | Status: ☐ Active ☐ Reservist ☐ Retired Mil Grade _____ | |
| City/State/Zip Code: | Branch: ☐ Marine Corps ☐ Navy ☐ Air Force ☐ Army ☐ DoD Civilian ☐ Other Mil Rank: _____ | |
| Home Phone (with area code): | ☐ Single Military ☐ Dual Military ☐ N/A ☐ Single Civilian ☐ Dual Civilian | |
| Cell Phone (with area code): | Housing: ☐ On Base ☐ Off Base | |

## SPOUSE / GUARDIAN

| | | |
|---|---|---|
| Spouse First Name: | Command/Unit/Employer: | |
| Spouse Last Name: | Wk Ph: | Extension: |
| Address 1: (if different from above) | Email: | |
| Address 2: | Status: ☐ Active ☐ Reservist ☐ Retired Mil Grade _____ | |
| City/State/Zip Code: | Branch: ☐ Marine Corps ☐ Navy ☐ Air Force ☐ Army ☐ DoD Civilian ☐ Other Mil Rank: _____ | |
| Home Phone (with area code): | Cell Phone (with area code): | |

## LOCAL EMERGENCY CONTACT / RELEASE DESIGNEES

| Name (first, last) | Address (include City/State/Zip Code) | Home Phone (with area code) | Cell Phone (with area code) | Relationship to Child |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

## CYTP INFORMATION

Child/Youth/Teen First & Last Name: | Nick Name:

Gender: ☐ Male ☐ Female Birthdate: _____ School Grade: _____ (K-12) or N/A

Program Enrollment:

☐ Full Day Care ☐ Part Day Preschool ☐ Family Child Care ☐ Hourly Care
☐ School Age Care (BF/AF) ☐ School Age Care (BF) ☐ School Age Care (AF) ☐ School Age Day Camp
☐ Youth Program (Age 6-12) ☐ Teen Program (Age 13-18) ☐ Other: _____ ☐ Off Base Family Child Care

Child/Youth/Teen First & Last Name: | Nick Name:

Gender: ☐ Male ☐ Female Birthdate: _____ School Grade: _____ (K-12) or N/A

Program Enrollment:

☐ Full Day Care ☐ Part Day Preschool ☐ Family Child Care ☐ Hourly Care
☐ School Age Care (BF/AF) ☐ School Age Care (BF) ☐ School Age Care (AF) ☐ School Age Day Camp
☐ Youth Program (Age 6-12) ☐ Teen Program (Age 13-18) ☐ Other: _____ ☐ Off Base Family Child Care

| **Please answer the following questions by adding your initials in the correct box** | **Yes** | **No** |
|---|---|---|
| I allow use of video and photographs of my child within the CYTP program. | | |
| I approve my child/youth to attend field trips. | | |
| I have received a copy or was given the website on where to get a “Parent Handbook”. | | |
| SAC/Youth/Teens - I give my permission for youth/teen to use supervised computers and internet. | | |
| I have received two CYMS cards per child. | | |

Parent/Guardian Signature | Date

## For office use only

| Registration Fee: | Amt: | Receipt #: | Amount Paid: | Paid on: | Rcvd by: |
|---|---|---|---|---|---|
| | | | | | |

Pass Issued: ☐ CY-Child ☐ CY-SAC ☐ CY-YT ☐ CY-YZZ-Privilege Pass

# DEPARTMENT OF DEFENSE CHILD DEVELOPMENT PROGRAM
# REQUEST FOR CARE RECORD

*(Read Privacy Act Statement and Instructions on back before completing form.)*

*OMB No. 0704-0515*
*OMB approval*
*expires May 31, 2017*



**PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO THE APPROPRIATE CHILD AND YOUTH PROGRAM REPRESENTATIVE.**

| **1. DATE OF REQUEST** *(YYYYMMDD)* | **2. EXPIRATION DATE** *(YYYYMMDD) (To be completed by Facility)* |
|---|---|
| | |

**3. FAMILY INFORMATION**

| **a. SPONSOR'S NAME** *(Last, First, Middle Initial)* | **b. SPOUSE'S NAME** *(Last, First, Middle Initial)* | |
|---|---|---|
| **c. CHILD'S NAME** *(Last, First, Middle Initial)* | **d. CHILD'S DATE OF BIRTH** *(YYYYMMDD)* | **e. CHILD'S AGE** |
| **f. HOME ADDRESS** *(Street, City, State, Zip Code)* | **g. SPONSOR'S BRANCH OF SERVICE** | |
| | **h. DUTY ORGANIZATION** | |
| **i. HOME TELEPHONE NUMBER** *(Include Area Code)* | **j. DUTY TELEPHONE NUMBER** *(Include Area Code)* | |

**k. SIBLING CARE**

| **(1) NAME** *(Last, First, Middle Initial)* | **(2) DATE OF BIRTH** *(YYYYMMDD)* | **(1) NAME** *(Last, First, Middle Initial)* | **(2) DATE OF BIRTH** *(YYYYMMDD)* |
|---|---|---|---|
| | | | |

**4. PROGRAM(S) DESIRED** *(X as applicable)*

| | | | |
|---|---|---|---|
| | **a. FULL-DAY CARE** | | **d. FAMILY DAY CARE (FDC)** |
| | **b. PART-DAY CARE** | | **e. PART-DAY ENRICHMENT** |
| | **c. SCHOOL-AGE** | | **f. PRE-SCHOOL** |

**5. AGE GROUP** *(X one)*

| | |
|---|---|
| | **a. INFANTS** *(0 - 12 months)* |
| | **b. TODDLERS** *(13 - 35 months)* |
| | **c. PRESCHOOL** *(3 - 5 years)* |
| | **d. SCHOOL AGE** *(5+ years)* |

**6. SPONSOR STATUS** *(X one)*

| | | | | | |
|---|---|---|---|---|---|
| | **a. SINGLE MILITARY** | | **e. SINGLE DOD CIVILIAN** | | **i. MILITARY/UNEMPLOYED SPOUSE** |
| | **b. DUAL MILITARY** | | **f. RETIRED MILITARY** | | **j. MILITARY/OTHER THAN DOD SPOUSE** |
| | **c. MILITARY/DOD SPOUSE** | | **g. MILITARY RESERVE** | | **k. OTHER** *(Specify)* |
| | **d. DUAL DOD CIVILIANS** | | **h. NATIONAL GUARD** | | |

**7. PRESENT CHILD CARE ARRANGEMENTS** *(X as applicable)*

| | | | | | |
|---|---|---|---|---|---|
| | **a. FCC ON-INSTALLATION** | | **d. CIVILIAN CDC** | | **g. IN-HOME CARE** |
| | **b. FCC OFF-INSTALLATION** | | **e. MILITARY ALTERNATE CARE** | | **h. NO PRESENT CARE** |
| | **c. OTHER MILITARY CHILD DEVELOPMENT CENTER (CDC)** | | **f. NON-MILITARY ALTERNATE CARE** | | **i. OTHER** *(Specify)* |

**8. GENERAL INFORMATION** *(X and complete as applicable)*

| **YES** | **NO** | | **YES** | **NO** | |
|---|---|---|---|---|---|
| | | **a. IF CHILD IS NOT PRESENTLY IN CARE, IS EMPLOYMENT OF SPOUSE IMPACTED?** *(If Yes, estimate average annual income lost)* | | | **c. IS CHILD ON OTHER MILITARY WAITING LIST?** *(If Yes, name installation)* |
| | | **b. HAS CHILD BEEN IDENTIFIED FOR SPECIAL NEEDS CARE?** | | | **d. CURRENT COST OF CARE PER WEEK** *(If child is currently in care)* |

**9. ACCOMMODATION UPDATES/REVERIFICATION** *(For Office Use Only)*

| | (1) | (2) | (3) | (4) | (5) |
|---|---|---|---|---|---|
| **a. DATE CALLED** *(YYYYMMDD)* | | | | | |
| **b. DECLINED/ PLACED** | | | | | |
| **c. COMMENTS/ INITIALS** | | | | | |
| **d. PLACEMENT TIME** *(In months)* | | | | | |

## PRIVACY ACT STATEMENT

**AUTHORITY:** 10 U.S.C. 3013, Secretary of the Army; 10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. 5041, Headquarters, Marine Corps; 10 U.S.C. 8013, Secretary of the Air Force; DoD Instruction 6060.02, Child Development Programs; Army Regulation 608-10, Child Development Services; OPNAV Instruction 1700.9 series, Child and Youth Programs; Marine Corps Order P1710.30E, Children, Youth, and Teen Program (CYTP); Air Force Instruction 34-248, Child Development Programs; and Air Force Instruction 34-249, Youth Programs, and 34-276, Family Child Care.

**PRINCIPAL PURPOSE(S):** To collect applicant information for Child Development Programs and establish waiting lists for program services. This information may also be used for statistical analysis, tracking, reporting, and evaluating program effectiveness. When completed, records are covered by one of the appropriate SORNS:
Department of the Army: http://dpclo.defense.gov/privacy/SORNsIndex/tabid/5915/article/6160/a0608-10-cfsc.aspx;
Department of the Navy: http://dpclo.defense.gov/privacy/SORNsIndex/tabid/5915/article/6527/nm01754-3.aspx;
Department of the Air Force: http://dpclo.defense.gov/privacy/SORNsIndex/DODwideSORNArticleView/tabid/6797/Article/5793/f034-af-sva-c.aspx

**ROUTINE USE(S):** Department of the Army records may be disclosed to civilian health and welfare departments/agencies in emergencies. Department of the Navy records may be disclosed to local, state and Federal officials involved in child care services, if required, in the performance of their official duties relating to child abuse reporting and investigations. Department of the Air Force records may be disclosed to civilian health and welfare departments/agencies in emergency situations.
DoD Blanket Routine Uses 1 (Law Enforcement), 4 (Congressional Inquiries), 6 (Required by International Agreement), 9 (Department of Justice for Litigation), 12 (National Archives and Records Administration), and 15 (Data Breach Remediation) specifically apply to this system. Other DoD Blanket Routine Uses found at http://dpclo.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx may apply to these records. Any release under a blanket routine use will be compatible with the purpose of the collection.

**DISCLOSURE:** Voluntary; however, if you fail to furnish the needed information, you might not be added to a waiting list or notified when there is space for your child.

## INSTRUCTIONS

This form is to be completed by authorized patrons (per Department of Defense Instruction 6060.02, Child Development Programs) and serves as the Official Request for Care for use of Department of Defense operated Child Development Programs. Providing this information is voluntary, but failure to complete the form may result in a denial of care.

1. Provide the date the request is completed.

2. To be completed by facility where care is requested. This form expires one year from the initial date of request.

3. Family Information.
a. Provide the sponsor's last name, first name and middle initial.
b. Provide the spouse's last name, first name and middle initial (when applicable).
c. Provide the last name, first name and middle initial of the child for whom care is being requested.
d. Provide the date of birth of the child for whom care is being requested.
e. Provide the age of the child for whom care is being requested at the time of application.
f. Provide the residential address of the child for whom care is being requested.
g. Provide the sponsor's branch of service. For DoD civilians, provide the service or agency of employment. If this is not applicable, enter NA.
h. Provide the organization to which the sponsor is employed. If this is not applicable, enter NA.
i. Provide the home telephone number of the sponsor.
j. Provide the work telephone number of the sponsor.
k. If the family is requesting care for additional children, enter their last name, first name, middle initial and date of birth, and complete a separate form for each child when applicable.

4. Program(s) Desired.
- Place an "X" to indicate the family's desire for where the child's need for care may be accommodated.

5. Age Group.
- Place an "X" to indicate the age group that the child falls on the date of application.

6. Sponsor Status.
- Place an "X" to indicate the status of the sponsor on the date of application.
- For "Other", specify the sponsor's status.

7. Present Child Care Arrangements.
- Place an "X" to indicate the present arrangement for child care of the child for whom care is being requested.
- For "Other", specify the sponsor's status.

8. General Information.
a. Indicate "Yes" or "No" if the lack of child care is impacting the ability of the spouse (where applicable) to find employment.
b. Indicate "Yes" or "No" if the child has been identified for special needs care.
c. Indicate "Yes" or "No" if the child is on other military waiting lists for child care. If, "yes", provide the name of the installation where the child is on a waiting list.
d. If the child is currently accommodated in non-DoD child care, indicate the weekly cost for care.

9. To be completed by the facility only.

# AUTHORIZATION TO RELEASE AND CONSENT TO EXCHANGE INFORMATION

I/We, _____,

I am/are the (Check one):

☐ Parent(s) ☐ Legal Guardian ☐ Agent Acting Pursuant to a Power of Attorney, for

_____ _____

(Name/student) (Date of Birth)

My/our mailing address:

## AUTHORIZATION

I authorize the following agencies and individuals to exchange confidential information pertaining to above named child/student:

(Agency Name, Title, and name of Specific Staff Contact Person or Designee)

AND

(Agency Name, Title, and name of Specific Staff Contact Person or Designee)

Additional agencies who may exchange information are listed on the back ☐ Yes ☐ No

## SOURCE AND TYPE OF INFORMATION

My consent to the exchange of information (except drug or alcohol abuse diagnoses or treatment information) applies to the following sources of information (initial all that apply):

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Assessment Information |
| ☐ | ☐ | Psychiatric Records |
| | | Educational Records |
| | | Psychological Records |
| | | Mental Health Diagnosis |
| | | Benefits/Services Information |

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Financial Information |
| | | Medical Diagnosis |
| | | Medical Records |
| | | Employment Records |
| | | Criminal Justice Information |
| | | |

Other Information that may be released or exchanged (specify): _____

The form of information that may be exchanged: (initial all that apply): _____Written _____Verbal _____Computerized Data

This information may be exchanged for the following purposes: (initial all that apply):

_____Service Coordination and Treatment Planning _____Eligibility Determination

_____Other (specify): _____

## ACKNOWLEDGEMENT

I have read and understand this authorization and consent will remain effective until I revoke it by notifying the agencies or individuals orally or in writing. This will stop the exchange of information authorized by this document. I understand that I have the right to know what information is being exchanged, and why, when, and with whom it was shared. At my request, the named agency or individuals will show me this information. A copy of this signed authorization and consent is valid to exchange information. If I do not sign this form, information will not be exchanged and I will have to contact each agency individually.

Print Name:_____ Signature:_____Date:_____

Print Name:_____ Signature:_____Date:_____

See Privacy Act Statement - Page 2

## PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), this notice informs you of the purpose for collection of information on this form. Please read it before completing the form.

**AUTHORITY:** 10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. 5041, Headquarters, Marine Corps; and E.O. 9397 (SSN).

**PRINCIPAL PURPOSE:** Information collected by this form will be used to prove parent consent to share information. The information collected on this form will be filed within a Privacy Act Systems of Records collection governed by Privacy Act System of Records Notice MO 1754-6 which can be downloaded at ***http://privacy.defense.gov/notices/usmc/MO1754-6.shtml..***

**RETENTION AND SAFEGUARDS:** SAMPLE: The collected information will be maintained in a database with restricted, limited access by authorized personnel who are properly screened, cleared, and trained. The database is protected by password, unique user IDs, and applicable layers of security access within applications. Records in this file system will only be retrieved by name and social security number. Records will be maintained indefinitely until a records disposition is approved.

**ROUTINE USES:** To various officials outside the Department of Defense specifically identified as a Routine Use in Privacy Act System of Records Notice MO 1040-2for the stated specific purpose in addition to those set out in the blanket routine uses established by the Department of Defense Privacy Office and posted at ***http://www.defenselink.mil/privacy/notices/blanket-uses.html.***

**DISCLOSURE:** Providing information on this form is voluntary (select one). Note: If parent does not complete the necessary data fields, EFMP will be unable to communicate with identified outside agency.

# U.S. Marine Corps Children, Youth & Teen Programs (CYTP) Health Assessment

**Privacy Act Statement:**

**AUTHORITY:** 10 U.S.C. § 5013; 10 U.S.C. § 5041; and Marine Corps Order P1710.30E. **PRINCIPAL PURPOSE:** This System of Records is governed by Privacy Act System of Records Notice NM01754-3 which can be downloaded at http://dpclo.defense.gov/privacy/SORNs/component/navy/NM01754-3.html. Information provided is used by USMC personnel to: (1) verify child required immunizations per admission requirements; (2)be used by the Inclusion Action Team to determine necessary and appropriate accommodations in CYTP activities.; (3) execute emergency medical procedure for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program; and (5) determine if at time of enrollment child is physically fit to participate in USMC CYTP programs. **ROUTINE USES:** In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, to various officials outside the Department of Defense (DoD) specifically identified in Privacy Act System of Records notice NM01754-3, and pursuant to the blanket routine uses established by DoD that apply to all DoD Privacy Act Systems of Records and posted at http://privacy.defense.gov/blanket_uses.shtml. **DISCLOSURE:** Information is voluntary; however, if information is not provided, individuals may not be able to participate in CYTP activities.

## SPONSOR INFORMATION (please print)

| Name of Sponsor | Sponsor Unit |
|---|---|
| | |

| Home Phone | Cell Phone | Duty/Work Phone |
|---|---|---|
| | | |

## CHILD/YOUTH INFORMATION (please print)

| Name of Child/Youth | Birth Date | ☐ Male ☐ Female | Enrolled in Public School ☐ Yes ☐ No |
|---|---|---|---|
| | | | |

## CHILD'S/YOUTH'S MEDICAL HISTORY (Check all that apply)

| | | | |
|---|---|---|---|
| 1. Any hospitalization or operations | | 14. Heat stroke or exhaustion | |
| 2. Allergies to medicine, insect bites, latex or food (please explain reactions) | | 15. Broken bones or sprains | |
| 3. Development delays/Learning problems | | 16. Joint injuries | |
| 4. Eye or vision Problems (Glasses/Contacts) | | 17. Restricted physical activity | |
| 5. Ear or hearing problems | | 18. Diabetes | |
| 6. Seizures or Convulsions | | 19. Cancer | |
| 7. Dizziness or fainting with exercise | | 20. Dental | |
| 8. Headaches | | 21. Mental Health Issues | |
| 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. Benign skin colorations (e.g., birthmarks) | |
| 13. Chest pain with exercise | | 26. Other problems | |

If any apply, please explain

| | |
|---|---|
| Is the child/youth enrolled in Exceptional Family Member Program? (Specify what branch of Service) ☐ Yes ☐ No _____ | Has your child been seen by a Health Care provider regarding their Special Need within the last year? ☐ Yes ☐ No |
| Does the child/youth have any special needs/considerations (including religious/cultural)? ☐ Yes ☐ No<br>* If there are special considerations, a Health Screening Tool for Inclusion Action Team will need to be completed by the healthcare provider. | Does the child/youth have ongoing medical concerns? (If Yes, explain circumstances and current status)<br>☐ Yes ☐ No _____ |

## PHYSICAL EXAMINATION (To be completed by Health Care Provider)(May attach last physical if within last 12 months)

| Height: | Weight: | BP: | HR: |
|---|---|---|---|
| | | | |

| | Normal | Abnormal | N/A | | Normal | Abnormal | N/A |
|---|---|---|---|---|---|---|---|
| 1. Eyes | | | | 8. Chest/Abdomen | | | |
| 2. ENT | | | | 9. Genitalia | | | |
| 3. Hearing | | | | 10. Skin | | | |
| 4. Mouth/Teeth | | | | 11. Lymphatic | | | |
| 5. Neck | | | | 12. Spine | | | |
| 6. Cardiovascular | | | | 13. Extremities | | | |
| 7. Respiratory | | | | 14. Neurological | | | |

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

Immunizations are current and up to date ☐ Yes ☐ No (if no, please explain) *A copy of the child/youth immunization must be given to CYTP.

Child/Youth is able to participate in normal CYTP programs? ☐ Yes ☐ No (if no, please explain) _____

| Date | Parent/Guardian Signature | **Health Care Provider Stamp or Printed Name & Address** |
|---|---|---|
| | | |
| Date | Health Care Provider Signature | |
| | | |

U.S. Marine Corps Children, Youth & Teen Programs (CYTP) Health Assessment
**Health Screening Tool for Inclusion Action Team (IAT)**

**REQUIRED ONLY IF THE CHILD/YOUTH HAS SPECIAL NEEDS/CONSIDERATIONS. TO BE COMPLETED BY PARENT AND HEALTH CARE PROVIDER OR APPROPRIATE SPECIALIST**

## Identification of Child/Youth Special Need(s) (use provided space to elaborate on the special need)

**What special need(s) does the child/youth have?**

Asthma/Reactive Airway Disease ☐ Allergies (other than seasonal/allergic rhinitis) ☐ Behavioral ☐ Neurological ☐
Developmental (e.g. Autism/PDD/Delays) ☐ Other (explain) ☐

Brief summary of the child's/youth's needs

## Medication

Child is on medications related to special needs? ☐ No ☐ Yes (list medications below and indicate which require administration during child care hours)

For medically diagnosed allergies, is Epinephrine required? ☐ Yes ☐ No

For other diagnoses, are any emergency medications required (e.g. Glucagon, Diastat, Albuterol)? ☐ Yes ☐ No

CURRENT MEDICATIONS INCLUDING EMERGENCY (If more space needed, please attach additional documents)

| Name | Dosage | Frequency | During Child Care |
|---|---|---|---|
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |

Assistance with activities of daily living? ☐ No ☐ Yes (explain)

Dietary modifications? ☐ No ☐ Yes (explain)

Environmental adaptations (e.g. room temperature, wheelchair access)? ☐ No ☐ Yes (explain)

Other conditions/adaptations/modifications/recommendations/concerns or comments to ensure the child's/youth's needs are met? (specify and explain) ☐ No ☐ Yes

☐ **N/A**

## Carry and Self-Administer Authorization (to be completed by health care provider)

☐ **YES** I have instructed this youth in the proper way to use his/her medication. It is my professional opinion that he/she SHOULD be allowed to carry and self administer his/her medication. This youth has been instructed not to share medications.

☐ **NO** It is my professional opinion that this child/youth SHOULD NOT carry or self administer his/her medication.

For youth who self-administer and carry their own medication(s), the medication MUST accompany the youth at all times. The options of storing "back up" rescue medications at the program is available. The youth must not share medications. Should the youth violate these restrictions the privilege of self medicating will be revoked and the youth parents notified. Youth are required to notify staff when carrying medication upon check in at CYTP activity.
*Rescue medications MUST accompany children/youth during any off-site activities.

| Health Care Provider or Specialist Signature | Date | **Health Care Provider Stamp or Printed Name & Address** |
|---|---|---|
| Phone | Email | |

## Early Intervention and Special Education

Child has an Individualized Family Service Plan (IFSP), Individualized Education Plan (IEP), 504 plan or Behavioral Plan? ☐ No ☐ Yes

If yes, does he/she have an aide, skills trainer, or additional assistance? ☐ No ☐ Yes

For Special Ed/Early Intervention, is the child currently seeing a therapist? ☐ No ☐ Yes

I understand that all reasonable efforts will be made to accommodate all properly documented special needs based on IAT determinations. Parent/guardian(s) will be notified if care accommodations cannot be honored and invited to attend subsequent meetings. I acknowledge that CYTP is not responsible for providing the child/youth with services that would be considered skilled nursing or behavioral, occupational, or physical therapy.
I understand that this form must be updated annually, or earlier, if there is a change in condition or need.

| Parent/Guardian Signature | Date |
|---|---|

## Office Use Only-Reviewed by CYTP Nurse or Other Designated Personnel

| Signature | Date | IAT Meeting date if required |
|---|---|---|

| Child Name |
| --- |
| |
| Sponsor Name |
| |
| Child's Date of Birth |
| |


# CHILD & YOUTH PROGRAMS
# STATEMENT OF UNDERSTANDING

As an enrolled parent of the Child & Youth Programs, I understand that the guidelines listed below are essential to ensure the health, safety, and general wellbeing of my child. Further, I understand that failure to comply with these regulations will result in adverse action being initiated on the part of management and the separation from Child & Youth Programs.

Please initial beside each statement.

FINANCIAL:

_____ I understand I cannot drop off my child before 0500 and must pick up my child no later than 1900 from the either the Child Development Center (CDC) and/or School Age Care (SAC) Center. There is a fee of $1.00 for every minute after closing. Prior notification must be provided to the appropriate center before utilizing the facility before 0630 and after 1730.

_____ I understand that fees are due by 1730 on the 1st and 15th of each month prior to receiving care. I understand that I may pay for as many weeks ahead of time as desired. I also understand there will be no discounts for holidays, weather, or illness.

_____ I understand that I will be charged $5.00 per hour, for every hour over 50 hours of care a week.

_____ I understand that after a 90 day initial service period a two weeks credit is given for vacation time per calendar year. In the event of an emergency please notify the front desk prior to departure to discuss fee arrangements.

_____ I understand if I choose to terminate my contract I must give a two week notice. Fees shall be paid during this period whether or not care is used.

HEALTH AND WELLNESS:

_____ PARENT/GUARDIAN CONSENT FOR EMERGENCY MEDICAL TREATMENT: I hereby appoint the Child & Youth Program to act as my agent in obtaining medical treatment required for my child(ren) in the event of an emergency situation where the child's condition represents a serious or imminent threat to his/her life, health, or well-being. I understand that a conscientious effort will be made to notify the parent/guardian prior to any such action or expense. Furthermore, I hereby authorize the Medical Department of the Navy to treat the child, employing such as is deemed medically or surgically advisable.

_____ I understand that my request to have over-the-counter medications available for administration to my minor child may cause a physical reaction(s) including, but not limited to, headache, vomiting, chills, gastrointestinal upset, diarrhea, and other associated physical reactions.

_____ I understand my child is not to be brought to any Child and Youth facility if he/she is ill. This includes, but is not limited to, a fever of 100 degrees or higher, vomiting, diarrhea, rash or discharge from the eyes. I understand that I will be notified by CYP staff if my child should become ill. I will have 1 hour to pick up my child before my emergency contact is notified to pick up my child. My child must be free of symptoms and fever reducing medication for 24 hours prior to returning to any CYP facility.

_____ I understand that parent education classes and resource are available upon request through the CYP Military Family Life Consultant (MFLC). I also understand that an MFLC is on site and may work with my child if necessary or requested.

_____ I understand that the policy of CYP is to put infants to sleep on their backs until the child is one year of age to reduce the risk of Sudden Infant Death Syndrome. This is a requirement set forth in accordance with MCO 1710.30 and guidance published by the American Academy of Pediatrics.

BEHAVIOR:

_____ I understand that if my child receives three inappropriate behavior reports in one day that I will be called and will be required to take my child home within 1 hour of receipt of the phone call.

_____ I understand that if my child displays consistent behavioral problems that hinder the teacher's ability to continue the program for the other children that I may be asked to meet with the program leads or the facility supervisor to create behavior action plan. If my child's behavior continues to be disruptive or case harm to him/herself or other children that my child may ultimately be unenrolled from the program.

_____ I understand that the CYP touch policy is based on the premise that positive physical contact with children is absolutely necessary for their healthy growth and development, whereas, a "no touch" policy creates a stark and unacceptable atmosphere for young children. Accordingly, providers shall provide appropriate positive physical contact and refrain from inappropriate touching. Children will always have the option to refuse being touched except in the case of protecting the children from a dangerous situation.

PARENT INVOLVEMENT:

_____ I understand that the Child and Youth Programs have a quarterly Parent Advisory Board (PAB) meeting. This meeting is to discuss upcoming events within the Programs and also gives families the opportunity to contribute ideas and input into improving the program as a whole. The PAB is open to all families with children in CYP.

_____ I understand that parent participation is highly encouraged. Any time that I want to share my special talents and/or skills I can contact my child's teacher so that it can be incorporated into the weekly curriculum.

GENERAL GUIDELINES:

_____ I understand that my child's picture/video will be taken for in house art work, displays, and identification. No pictures will be posted on Social Media without prior parent approval.

☐ Please check IF: I <u>DO NOT</u> authorize my child to be pictured or videotaped other than CCTV.

_____ I understand that I must bring my child in appropriate clothing for the weather, to include a jacket during the winter months. I understand that if my child is attending the CDC he/she must have extra clothes available at all times, and wear socks, as well as closed-toed shoes. My child will also need a blanket for naptime.

_____ I understand that no toys from home are to be brought to the CDC. No candy, gum or other food may be brought to the center without prior permission from program leads or the supervisor. Birthday cakes, cupcakes, etc. must be store bought.

_____ I understand that I will be offered a parent-teacher conference in the fall and spring but that I may request a private conference with my child's teacher, program lead or facility supervisor at any time.

_____ I understand I must have written authorization on file in order to have my child released to anyone other than myself or spouse. The appropriate center must be notified when someone other than myself/sponsor is going to be picking up my child.

_____ I understand that I must update my file ANNUALLY to remain compliant with HQMC requirements and keep my child in care.

_____ I acknowledge that I have read and reviewed the parent handbook and received a parent orientation upon request.

ELECTRONICS POLICY:

_____ Child & Youth Programs (CYP) along with the Boys' and Girls' Club have taken proactive steps to ensure your child's safety while using the internet service at any of our facilities. While we use internet filters in an attempt to block inappropriate websites and material, your child may gain access to these items. The internet is always changing, and it is virtually impossible to block all inappropriate material that can be found.

_____ I understand that users are not authorized to tamper with any of the computer settings. Users will be held liable for any damages caused to the hardware and software.

_____ I understand that users will be limited to one (1) hour, unless no one else is waiting. Computers will be shut down 15 minutes prior to closing time.

_____ I understand that food and beverages are not allowed in the computer area.

_____ I understand that viewing or downloading any material containing nudity or pornography is not permitted as regulated by local law. This is an illegal act, and if a user is caught viewing a sight that is inappropriate they will lose all internet privileges for the rest of the school year.

_____ I understand that any attempted access to restricted material will warrant immediate pick up by parent/guardian. Prior to the child returning to any CYP facility a parent and site supervisor conference shall be held.

_____ I understand that computer equipment used by youth is subject to monitoring at all times.

Please circle YES or No.

YES/NO I give permission for my child to have access to the internet while at a CYP facility.

YES/NO I give permission for my child to play computer games while at a CYP facility.

YES/NO I give permission for my child to play X-Box 360/PlayStation/Wii games at a CYP facility.

*Please note: children ages 10-12 only have access to games rated E

Sponsor's/Parent's Signature: _____
Date_____