

**CHILD & YOUTH PROGRAMS  
SPECIAL EVENT CHILDCARE**

Child/Youth Name	CYP Facility
	<ul style="list-style-type: none"> <li><input type="radio"/> Child Development Center                             <ul style="list-style-type: none"> <li><input type="radio"/> Infant (6 weeks-12 months)</li> <li><input type="radio"/> Pre-Toddler (12-24 months)</li> <li><input type="radio"/> Toddler (24-36 months)</li> <li><input type="radio"/> Preschool (3-5)</li> </ul> </li>   <li><input type="radio"/> School Age Care Center</li> </ul>
Date of Birth	
Date of Special Event	

**The following documentation is included in this registration package:**  
Each of the items must be included in the registration package in order for your request to be processed.

- Registration Form (NAVMC 11903)
- Statement of Special Needs, Medical or Developmental Conditions
- Immunization Record (up to date- CDC only)
- IAT (if applicable)
- Short Term Childcare Support Statement of Understanding

**Comments:**

**FOR OFFICE USE ONLY**

\_\_\_\_\_  
**CYP Representative**

\_\_\_\_\_  
**Date**

## 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](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: <input type="checkbox"/> Active <input type="checkbox"/> Reservist <input type="checkbox"/> Retired	Mil Grade _____	
City/State/Zip Code:	Branch: <input type="checkbox"/> Marine Corps <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Army <input type="checkbox"/> DoD Civilian <input type="checkbox"/> Other	Mil Rank: _____	
Home Phone (with area code):	<input type="checkbox"/> Single Military <input type="checkbox"/> Dual Military <input type="checkbox"/> N/A		
Cell Phone (with area code):	<input type="checkbox"/> Single Civilian <input type="checkbox"/> Dual Civilian		
Housing: <input type="checkbox"/> On Base <input type="checkbox"/> 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: <input type="checkbox"/> Active <input type="checkbox"/> Reservist <input type="checkbox"/> Retired	Mil Grade _____	
City/State/Zip Code:	Branch: <input type="checkbox"/> Marine Corps <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Army <input type="checkbox"/> DoD Civilian <input type="checkbox"/> 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

**NAVMC 11903 (09-13) (EF)**

FOUO - Privacy sensitive when filled in.

**CYTP INFORMATION**

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

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

Program Enrollment:

<input type="checkbox"/> Full Day Care	<input type="checkbox"/> Part Day Preschool	<input type="checkbox"/> Family Child Care	<input type="checkbox"/> Hourly Care
<input type="checkbox"/> School Age Care (BF/AF)	<input type="checkbox"/> School Age Care (BF)	<input type="checkbox"/> School Age Care (AF)	<input type="checkbox"/> School Age Day Camp
<input type="checkbox"/> Youth Program (Age 6-12)	<input type="checkbox"/> Teen Program (Age 13-18)	<input type="checkbox"/> Other: _____	<input type="checkbox"/> 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:

<input type="checkbox"/> Full Day Care	<input type="checkbox"/> Part Day Preschool	<input type="checkbox"/> Family Child Care	<input type="checkbox"/> Hourly Care
<input type="checkbox"/> School Age Care (BF/AF)	<input type="checkbox"/> School Age Care (BF)	<input type="checkbox"/> School Age Care (AF)	<input type="checkbox"/> School Age Day Camp
<input type="checkbox"/> Youth Program (Age 6-12)	<input type="checkbox"/> Teen Program (Age 13-18)	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Off Base Family Child Care

<b>Please answer the following questions by adding your initials in the correct box</b>	<b>Yes</b>	<b>No</b>
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



**CHILD & YOUTH PROGRAMS**  
**Statement of Special Needs, Medical or Developmental Conditions**

**Purpose:** To provide child and family program eligibility and background information; to assist with child’s placement and obtain sponsor consent for access to emergency medical care; and to provide data required by EFMP. Policies shall be implemented to ensure that appropriate services are provided for children, youth and teens with special needs. Such policies shall meet the requirement of the Rehabilitation Acts and the Department of Defense Directive 1020.1, Non-Discrimination on the Basis of Handicap in Programs and Activities Assisted or Conducted by the Department of Defense.

**Routine Uses:** This information will be shared with members of the Inclusion Action Team (IAT) to assist with making an informed decision about your child’s placement. Information is used for program admission to ensure staff training is pertinent to the child’s needs. Information is furnished for the attending physician when it is necessary for a child to be taken to a medical facility by someone other than the parent.

**Disclosure:** Disclosure of information is voluntary; however, if information is not provided, individuals may not be allowed to participate in Child and Youth Programs. Please note any medication your child may take, or has taken consistently in the last six months.

Child/Youth Name (Last, First)	Sponsor Name	Date of Birth	Program (Circle)
			CDC   SAC   Youth &Teen

**Please check (✓) if your child has any of the following:**

	Asthma Please indicate severity/triggers:
	Apnea
	Autism (to include PDD-nonspecific, Asperger’s Syndrome, or any Pervasive Developmental Disorder)
	Allergies (severity allergies to bee stings, severe environmental or severe food allergies; severe is defined as “life threatening conditions occur when contact with allergen is made”)
	Any chromosomal disorder (such as Down Syndrome, Velo-Cardio Facial Syndrome, X-chromosome disorders or a mutation of any chromosome)
	Seizure Disorder Please indicate type:
	Diabetes
	(Infants Only) Prematurity, as defined as born before 36 weeks gestation
	Developmental Disability (mental retardation)

Developmental Delay Please check all that apply: <input type="checkbox"/> communication or speech delay <input type="checkbox"/> emotional delay <input type="checkbox"/> motor/physical skill delay
Blood disorder (such as hemophilia) <b>Note: If child is HIV positive, do not indicate it on this form. To safe guard your child's confidentiality, you may choose to reveal your child's HIV status to the director. This will aid the program in providing services to safeguard you child's health.</b>
Attention Deficit Disorder with/without Hyperactivity (ADD/ADHD)
Severe Behavior Disorder (SBD)
Obsessive Compulsive Disorder (OCD)
Other mental health condition (such as paranoia or schizophrenia)
Hard of hearing or deaf
Blind
(For toddlers, preschoolers and school-aged children) Unable to walk, including children using a wheelchair
Suffered several physical trauma (due to incidents such as, but not limited to, automobile accident, a severe fall, physical abuse)
Suffered severe emotional trauma (due to incidents such as, but not limited to, any type of abuse, death of a parent or sibling)
Digestive Disorder Specify:
Respiratory Disorder Specify:
Chronic Heart Condition
Disorder of the spine or skeletal system (such as scoliosis)
Missing limb
Other special needs or medical conditions not listed. Specify:
Routine Medications Specify:
Required special care or services Specify:
<b>My child has NO special needs or diagnosed condition(s).</b>

If your child has been identified with any special needs, are you currently enrolled in the Exceptional Family Member Program?       YES       NO

I have disclosed, to the best of my ability, any special needs, medical, or developmental conditions my child may have.

<b>Sponsor's/Parent's Signature:</b> _____	<b>Date</b> _____
--	-------------------

<b>Child Name</b>
<b>Sponsor Name</b>
<b>Date of Birth</b>



**CHILD & YOUTH PROGRAMS**  
**Statement of Understanding**  
**Short Term Care**

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.

**GENERAL GUIDELINES:**

- \_\_\_\_\_ I understand that this short term childcare registration packet is a one-time use application and will expire 30 days from the conclusion of the special event's specified date.
- \_\_\_\_\_ I understand the pickup time for this specific event. The provost marshal office (PMO) will be contacted if children are left at the center 30 minutes after the scheduled pickup time of the event.
- \_\_\_\_\_ I understand that a fee may be assessed if my child is left in care longer than the designated time.
- \_\_\_\_\_ I understand I must have written authorization on file in order to have my child released to anyone else other than myself or spouse.
- \_\_\_\_\_ I understand that it is the responsibility of the sponsor to ensure all information given to the Child and Youth Programs is accurate and updated annually, including emergency contacts and any significant medical information.
- \_\_\_\_\_ I understand that I must label all items such as bottles, jar food, bags, etc.
- \_\_\_\_\_ I understand MCCS is not responsible for any items that are lost or stolen.

**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.

\_\_\_\_\_ I understand that CYP personnel and FCC providers are mandated to report any suspected child maltreatment or neglect.

**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 cause 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.

**ELECTRONICS:**

\_\_\_\_\_ 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 thirty minutes, 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. (Please note: youth are authorized to use social networks such as Facebook and YouTube.)

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.

YES/NO I give permission for my child to play games rated T (Teen).

\*Please note: children ages 10-12 only have access to games rated E; however youth ages 13-18 have access to games rated both E and T. Titles rated T (Teen) have content that may be suitable for ages 13 and older. Titles in this category may contain violence, suggestive theme, crude humor, minimal blood and/or infrequent use of strong language.

**Sponsor's/Parent's Signature:** \_\_\_\_\_

**Date** \_\_\_\_\_



# TIPS FOR USING A CYP FACILITY

## CHILD DEVELOPMENT CENTER

<b>Hours of Operation</b>	Monday-Friday from 0500-1900 Closed on weekends and federal holidays
<b>Phone Number</b>	253-5584 (DSN)
<b>Items to Bring</b>	Infants (6 weeks to 12 months) <ul style="list-style-type: none"><li>• Diapers (at least 8)</li><li>• Wipes</li><li>• Pacifier (if desired)</li><li>• Extra set of clothes</li><li>• 4-5 pre-made, plastic bottles (please label with your child's name and the date)</li></ul> 1-3 Years <ul style="list-style-type: none"><li>• Diapers</li><li>• Wipes</li><li>• Blanket</li><li>• Extra set of clothes</li><li>• Toothbrush and toothpaste</li><li>• Closed-toed shoes</li></ul> 3-5 Years <ul style="list-style-type: none"><li>• Blanket</li><li>• Extra set of clothes</li><li>• Toothbrush and toothpaste</li><li>• Diapers and wipes if needed</li><li>• Closed-toed shoes</li></ul>



## SCHOOL AGE CARE CENTER

<b>Hours of Operation</b>	Monday-Friday from 0600-1900 Closed on weekends and federal holidays
<b>Phone Number</b>	253-4769/3115 (DSN)
<b>Items to Bring</b>	Closed-toed shoes
<b>Extra Information</b>	Children attending the SAC cannot sign themselves out. They must stay at the center until a parent or designated emergency contact picks them up. Breakfast, lunch and an afternoon snack will be provided at no cost.

## YOUTH AND TEEN CENTER

<b>Hours of Operation</b>	School Hours: Monday-Thursday from 14:30-1900, Friday from 14:30-2000, Saturday from 1200-2000 Closed on Sunday and holidays
<b>Phone Number</b>	Summer Hours: Monday-Friday 0900-1900, Saturday from 1200-2000 Closed on Sunday and holidays 253-6454 (DSN)
<b>Extra Information</b>	This is an open recreation area for youth ages 10-18. Children who come to the Youth and Teen Center can sign themselves in and out once proper paperwork has been completed. No snack or lunch will be provided; the child will have to get their own lunch.

**Questions or Concerns? Contact your Resource & Referral Office at 253-5064 (DSN)**