

# 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: 3 <sup>rd</sup> Grade)	Date of Birth (YYYYMMDD)	Age
Type of Placement Requested: (check all that apply)			
<input type="checkbox"/> Hourly Care	<input type="checkbox"/> Full Day Care	<input type="checkbox"/> Middle School/Teen Program	<input type="checkbox"/> Summer Camp
<input type="checkbox"/> Part Day Care	<input type="checkbox"/> Before/After School Care	<input type="checkbox"/> SKIES/Instructional Classes	<input type="checkbox"/> Other: (specify)
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 your child have any of the following conditions/restrictions: (check no or yes and answer questions as appropriate)

<p>1. Allergies</p> <p>a. Life threatening reaction? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>b. Rescue Medication (Epi-pen, Benadryl, Inhaler) <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>c. Does child/youth need rescue inhaler? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If your child/youth has an allergy, please list: _____</p> <p>Reaction: _____</p> <p>2. Special Diet <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>a. Is your child on a complex diet (i.e. gluten free, diabetic) <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>b. Does your child have a food intolerance/mild food allergy (i.e. rash from strawberries/milk intolerance)? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>c. Does your child have a dietary religious restriction? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>3. Asthma/Reactive Airway Disease/Breathing Problems? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>a. Does your child need a rescue med? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>4. Does your child have diabetes? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>5. Does your child have seizures? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>6. Attention Deficit Disorder (ADD/ADHD)</p> <p>a. Are there behavior/conduct concerns while on meds? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>b. List ADD/ADHD medications: _____</p> <p>_____</p> <p>_____</p>	<p>7. Behavior/ conduct concerns (oppositional defiant disorder, anxiety, depression, bipolar, other)? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>8. Autism Spectrum Disorders (Autism, Aspergers, Rett Syndrome, PDD-NOS) <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>9. Does your child have any of the following health concerns? (circle all that apply)- Hearing impairment, vision impairment <u>other than corrective lenses</u>, heart, kidney, physical disability SEVERE skin condition <input type="checkbox"/> No <input type="checkbox"/> Yes Please specify _____</p> <p>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)? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain: _____</p> <p>11. Does your child have developmental delays other than MILD speech language/MILD hearing loss? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain: _____</p> <p>12. Are there any other conditions or concerns that you would like staff to be aware of? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain: _____</p>
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## 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? <input type="checkbox"/> No <input type="checkbox"/> Yes Please specify: _____	Does your child/youth have an Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP) or 504 Plan? <input type="checkbox"/> No <input type="checkbox"/> Yes
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## Part E – Exceptional Family Member Program (EFMP) Enrollment

Is your child enrolled in the EFMP?  No  Yes If yes, specify for what condition: \_\_\_\_\_

\_\_\_\_\_  
Printed Name and Signature of Parent/Personal Representative of Child/Youth

\_\_\_\_\_  
Date (YYYYMMDD)

**If you have answered NO to all the questions above you are now finished with this form.**

Please sign and date indicating that the information above is accurate and complete to the best of your knowledge.

Child, Youth and School Services strives to provide the safest and healthiest environment for your child/youth and relies on your accurate and honest information to support this goal. Please understand that placement and/or care for your child/youth could be delayed/suspended if information is falsified or intentionally omitted on registration documentation. If there are any changes to your child/youth's health please notify CYS Services immediately.

**If you answered YES to any of the questions above, complete Part F on the next page.**

Child/Youth Name	Date of birth (YYYYMMDD)	Age
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**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: