CDC Registration Checklist

The following documents are required to register your child. Bring the complete packet with all documentation to your Central Registration appointment.

*NOTE: A space will not be offered until registration packet is complete.

_____ AF Form 1181(All information is required except the immunization portion which is provided separately. Only the last 4 of the Social Security Number is necessary.)
_____ Updated immunizations (to include the current flu shot)
_____ AF Form 2652 with both parents signature
_____ LES/Paystub of both parents within the last 30 days (not required if CAT 9)
_____ Full Time Student Enrollment Verification
_____ Signed FY 17 Program Agreement
_____ Health screening tool (All questions must be answered. If you mark yes to any question, you will need additional paperwork before registration can be completed.)
_____ Video/Photography policy
_____ Auto pay form
_____ Health assessment (Due 6 weeks after enrollment)
_____ USDA enrollment form
_____ 30 Day Notice (if applicable)

For Central Registration use:

Total Family Income (TFI) calculation _____

Date of Appointment:_____

Child Name:_____

CDC:_____

Start date: _____

$50 non-refundable deposit paid _____

APPLICATION FOR DEPARTMENT OF DEFENSE CHILD CARE FEES

(Read 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 ADDRESS. RETURN COMPLETED FORM TO THE APPROPRIATE CHILD AND YOUTH PROGRAM REPRESENTATIVE.

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 total family income to determine child care fees. 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, failure to furnish all requested information will result in application of the highest fee range.

SECTION I - DEPENDENT CHILDREN

	1. NAME OF EACH CHILD *(LAST, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. AGE	4. CARE REQUESTED (OR ENROLLED)
a.				
b.				
c.				
d.				
e.				

SECTION II - ANNUAL FAMILY INCOME

5. SPONSOR

a. NAME *(LAST, First, Middle Initial)*	b. YEARS OF MILITARY/CIVIL SERVICE

c. INCOME

(1) Income Data	(2) Basic Allowance for Housing (BAH)	(3) Basic Subsistence Allowance	(4) Other Earned Income	(5) Total Income - Sponsor *(To be completed by Program Staff)*

6. SPOUSE OR OTHER ADULT LIVING IN THE HOME

a. NAME *(LAST, First, Middle Initial)*	b. INCOME

7. OTHER EARNED INCOME	8. TOTAL INCOME *(Include income from Blocks 5, 6, and 7. To be completed by Program Staff.)*

SECTION III - CERTIFICATION OF SPONSOR/DESIGNEE

(Required for Category I - IX. Please read the following statement carefully before signing.)

I certify that all of the above information is true and correct and that all family income of the spouse and sponsor is reported. I understand that this information is being given in order to determine child care fees to be paid and that Federal funds are used to subsidize the cost of child care. I also understand that the installation commander may verify the information on the application; and that deliberate misrepresentation of this information may subject me to prosecution under applicable State and Federal laws. See 18 U.S.C. Section 1001.

9. SIGNATURE OF SPONSOR	10. SIGNATURE OF SPOUSE	11. DATE SIGNED *(YYYYMMDD)*

SECTION IV - FOR CHILD DEVELOPMENT PROGRAM USE ONLY

12. CATEGORY OF APPROVAL	13. AUTHORIZED FEES	14. DATE OF APPROVAL *(YYYYMMDD)*	15. NAME OF CHILD DEVELOPMENT PROGRAM OFFICIAL

INSTRUCTIONS

Per Department of Defense Instruction 6060.02, Child Development Programs, this form is utilized to determine fees for DoD Child Care Programs.

To determine child care fees for your child(ren), or and child(ren) you legally claim as dependents, this from must be completed, signed and returned to the facility for which your child is enrolling.

Fees are determined based on your Total Family Income (TFI) as defined below. If you choose not to disclose your family income, your rate for child care will be set at the highest fee level.

Total Family Income (TFI) - For the purpose of determining child care fees in DoD Child Development Programs, total family income is defined as all earned income including wages, salaries, tips, special duty pay (flight pay, active duty demo pay, sea pay) and active duty save pay, long-term disability benefits, voluntary salary deferrals, retirement or other pension income including SSI paid to the spouse and VA benefits paid to the surviving spouse before deductions for taxes. TFI calculations must also include quarters subsistence and other allowances appropriate for the rank and status of military or civilian personnel whether received in cash or in kind.

DO NOT INCLUDE alimony, and child support received by the custodial parent, SSI received on behalf of the dependent child, reimbursements for educational expenses or health and wellness benefits, cost of living (COLA) received in high cost areas, temporary duty allowances, or reenlistment bonuses.

For households in which unmarried couples or pairs are living as a family, the income for both adults should be used to determine Total Family Income (TFI).

Sections I, II, and III are to be completed by the sponsor or their designee.

Section I.

1. Provide the last name, first name and middle initial for each child who is receiving care in a DoD child care program.

2. Provide the date of birth for each child who is receiving care in a DoD child care program.

3. Provide the age of each child on the date of application who is receiving care in a DoD child care program.

4. Provide the type of care being request or in which each child is currently enrolled.

Section II.

When completing Section II, include all military and civilian income for both the sponsor and spouse or other adult living in the home.

5.a. Provide the sponsor's last name, first name and middle initial.

5.b. Provide the total years of military/civilian service as applicable.

5.c.(1) Provide your most recent income data and indicate if income is received weekly, biweekly, monthly or twice per month.

5.c.(2) Provide the current year BAH RT/C. For dual military living in government quarters include BAH RC/T of the senior member only; in locations where military members receive less than the BAH RC/T allowance, use the local BAH rate; for Defense civilian OCONUS include either the housing allowance or the value of the in-kind housing.

5.c.(3). Provide the basic subsistence allowance or in-kind equivalent.

5.c.(4) Provide any other earned income.

5.c.(5) To be completed by program staff.

6.a. Provide the last name, first name and middle initial of the spouse or other adult living in the home, who contributes to the welfare of the child.

6.b. Provide the income of the spouse or other adult living in the home, who contributes to the welfare of the child.

7. Provide any additional income.

8. To be completed by program staff.

Section III.

9. Provide the sponsor's signature.

10. Provide the spouse's or other resident adult's signature.

11. Provide the date of signatures.

Joint Base Elmendorf-Richardson
Child Development Program Agreement FY17

1. **Care:** The Child Development Program offers care between the hours of 0600 through 1730 Monday through Friday. I agree to accept the child care slot offered at _____CDC for my child, _____ age_____admission on _____(date). I also agree to pay a $50.00 deposit, which will be applied to my account when my child begins care. However, should I decide not to accept this slot after agreeing to do so, this deposit is non-refundable. I understand I am required to complete the Health Assessment form for my child within six weeks from the date above. All children may be subject to closed circuit video monitoring and recording as part of their participation/ enrollment in CYP.

2. **Payment of Fees:** Program fees are based on total family income. Fees may be paid weekly, bi-monthly or monthly. Patrons are required to provide a credit card number or debit card on the application and agree to have the card charged or account debited for the child participating in the program. Patrons can pay fees by check, cash, money order, credit or debit card (Visa or MasterCard). Payments will not be taken over the phone. Checks will not be accepted without personal information as required by AFI 34–212, paragraphs 4.16.3. Patrons are reminded that they are responsible for keeping personal records of child care fees for tax purposes. If requested, the Child Development Program will print out annual payment information for tax purposes. Category fees are set annually, fee adjustments, such as, hardship waivers and requests not to have credit card information on file are approved by the Mission Support Group Commander. All requests must be in writing to the center Director. Request for a reduction of fees, if approved, will not be retroactive. A discount is provided for families who have multiple children enrolled in the center. Patrons pay the full fee for the youngest child (highest rate) and other children from the same family enrolled in the program will each receive a multiple child discount of 10%. If patrons have children enrolled in both the center and School Age Program, the discount is given at the School Age Program.

3. **Fees for Children Absent During Prolonged Illness:** Parents of a child who are absent from the regular weekly program may request credit consideration, if the child's absence is more than five (5) business days, and: 1) is due to a diagnosed chronic/serious illness which may require treatment, or 2) is due to an extended period of hospitalization. In either case, medical documentation will be required to support the request. Any such request for credit will be submitted to the center Director and forwarded through the Flight Chief for recommendation to the Force Support Squadron Commander for approval or disapproval. Normal childhood diseases will not be credited (such as, chicken pox, colds, conjunctivitis, diarrhea, strep throat, viral rashes, etc).

4. **Hourly Care Credit:** Parents who would like the opportunity to earn a fee credit (based on family's category hourly rate) must notify the CDC prior to 0730 on the day their child/ren will not be in attendance. If their slot can be filled with an hourly care child during the coordinated absence, the full-time parent will receive an hourly credit based on their total family income during the next weeks' fees based on the number of hours utilized by the hourly patron.

5. **Late Fees:** In the event that you do not make payment on your account by the close of business on the second business day of the week, the credit/debit card on file will be charged for the full amount owed. If for any reason the back-up payment authorization cannot be used, parents will be notified and assessed a $10.00 late fee PER DAY up to the 4th working day of the week. After that time care will be denied. For example: If payment is due on Monday, 1st business day, parents have until close of business Tuesday, 2nd business day, to make payment. If payment is not received, their credit/debit payment authorization will be used. If for some reason late payment authorization could not be used, a late fee of $10.00 will be assessed on Wednesday, 3rd business day and every day after until the 4th

business day. If payment is not received by Friday or 5th business day, care will be denied. Fees not received in accordance with the above schedule could result in the patron's child/ren being terminated from the program. The Child Development Centers close at 1730 daily. After the hour of 1730, parents will be charged a late fee of $1.00 per minute, per child. There will be a $5.00 charge to replace lost key fobs.

6. **Vacation:** Vacation time is not given in the Child Development Programs. Parents in coordination with the Child Development Center may sublet or rent their space to another family not currently enrolled in the program. It is the responsibility of the parent to make all arrangements with the sublet family. The current parent must make the payment to the center and the subletting family must reimburse the current parent. Payment must be made in advance. The sublette's child must meet all CDC requirements for admittance.

7. **Termination:**

    a. All patrons must give a 2-week written notice when care is terminated.
    b. The Child Development Centers, after 30 days from enrollment the center Director will terminate care unless spouse has obtained:
        * Full-time employment (i.e, at least 32 hours per week) outside the home
        * Spouse enrolled in school full-time (at least 12 undergraduate credit hours or 9 graduate credit hours) are considered employed as long as they show proof of enrollment.
    c. 30 days after employment has been obtained, combined family income based on both pay statements will be used to determine the fee category. A new DD Form 2652 will be required at this time. If pay statements are not provided, care will be terminated. _____(Initial)

8. **Holidays/Family Days:** The Child Development Program will be closed on all scheduled and unscheduled Federal Holidays. Fees remain the same when there is a Federal Holiday. The Child Development facilities will assist parents in finding alternative care for working parents on Family Days, Down Days, and Training Days. There may be a possibility of a center opening on a rotational basis if the need cannot be met in FCC.

9. **Natural Disasters:** Natural events beyond our control, which cause less than 3 days closure, are not refundable. Examples of these include, but are not limited to, the following: earthquakes, power outages, snowstorms, volcanic eruptions, water line breakage, etc. The centers follow base delayed openings and early release schedules. Notification will be given on the Facebook page.

10. **Allergy Information:** Parents give consent to post allergy information in the child's classroom and in the food preparation areas of the center with pictures of the child to ensure children are not exposed to items they are allergic to.

11. **Emergency Contact Information:** Families are required to have a minimum of three local emergency contacts with phone numbers in the event of an emergency and parents cannot be contacted.

12. **Revisions:** The Child Development Program may modify any portion of this contract, in writing, at any time. Patrons have 3 duty days to accept the agreement as modified. Either party may cancel this agreement with 2 weeks written notice. The two-week written notice will include the 3-duty day acceptance period and can be waivered upon request and as needed.

I have read and understand the above conditions of the Child Development Program Agreement and am choosing to enroll my child/ren, _____ with the effective start date of _____. I agree to the fee rate indicated on the most current DD Form 2652. This program agreement is valid from date of signature to 31 October 2017.

_____ _____
Patron's Signature Date

_____ _____
Center Representative Date

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? (circle all that apply)- Hearing impairment, vision impairment other than corrective lenses, heart, kidney, physical disability SEVERE skin condition □ No □ Yes
   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.

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

SPECIAL NEEDS ACCOMMODATION PROCESS (SNAP) ACTION PLAN – TOOL #2

(copy to be kept in child/youth's care module)

Child's Name	Date of Birth (YYYYMMDD)	Date of SNAP

Diagnosis:	Date of Annual Review:

Approved for the following CYS Program: □ All CYS Programs/services □ CDC □ FCC □ SAS

□ Middle School/Teen □ Sports □ SKIES/instructional classes

□ Other:_____

Approved for the following CYS Service: □ Hourly □ Part Day □ Full Day

RECOMMENDATION

□ IEP goals/interventions □ IFSP goals/interventions □ Copy of 504 goals/interventions
□ Copy of Behavioral Assessment/Plan
□ Copy of MAP Type: _____ Other:_____

Medications: (only list medications to be administered while child is at the CYS program site)

Activity Restrictions/Adaptive Equipment, etc:

Training for CYS Staff/Provider Required:

Recommendation Summary:

I concur with this plan as outlined above.

_____ _____
Printed Name & Signature of EFMP Manager, Chair SNAP Team Date (YYYYMMDD

_____ _____
Printed Name & Signature of Child/Youth Services Coordinator/Designee Date (YYYYMMDD)

_____ _____
Printed Name & Signature of Army Public Health Nurse Date (YYYYMMDD)

_____ _ _____
Printed Name & Signature of Parent Date (YYYYMMDD)

Form Updated: 11 Mar 09

Child Development Program
Photograph/Videotape Release

I do/do not (circle one) give permission for my child, _____ , to be photographed/videotaped while at the Child Development Program.

I understand these photographs/videotapes may be used for training purposes in the Child Development Program. The photographs/videotapes may also be used in the classroom for activities and/or memory book.

_____ _____

Parent Signature Date

ATTACHMENT 1

Credit Card Recurring Payment Authorization Form

Schedule your payments to be automatically charged to your credit card. Just complete and sign this form to get started!

Recurring Payments Will Make Your Life Easier:

- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town), eliminating late charges

Here's How Recurring Payments Work:

You authorize regularly scheduled charges to your Visa, or MasterCard. You will be charged each billing period for the total amount due for that period. A receipt will be emailed to you and the charge will appear on your credit card statement. You agree that no prior-notification will be provided if the total payment is under the amount authorized below. If your bill is more than that amount, or the payment date changes, you will receive notice from us at least 10 days prior to the payment being collected.

Please complete the information below:

I _____ authorize _____ to charge my credit card indicated (full name) below on:

The first of each month for payment of my _____ in the amount of _____.

The 1st and 15th of each month for payment of my _____ in the amount of _____.

The first Monday of each week for payment of my _____ in the amount of$_____.

I understand that I will only receive advance notice of the charge if it exceeds an amount different than authorized.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard

Cardholder Name _____

Account Number _____

Expiration Date _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

	Child & Adult Care Food Program Child Enrollment Form	**State of Alaska** **Teaching and Learning Support** **Child Nutrition Programs** Phone (907) 465-8711 Fax (907) 465-8910

Institution Name: _____ _____CIS/CACFP Number

Facility/Provider Name: _____ Start Date:_____

Dear Parent/Guardian,
Your day care facility participates in the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). CACFP needs verification of enrollment for each participant in this facility. Please complete the table below for all children in your household that are enrolled at this facility. The information below should be completed by the parent/guardian. Please use the guides below the table to complete and sign and date the form below.

Child's First Name	Child's Last Name	Date of Birth	Normal/Typical Hours of Care	Normal/Typical Days of Care (Circle all that apply)	Meals Normally Eaten (Circle all that apply)
			_____ to _____	M T W TH F	B L PM
			_____ to _____	M T W TH F	B L PM
			_____ to _____	M T W TH F	B L PM
			_____ to _____	M T W TH F	B L PM
			_____ to _____	M T W TH F	B L PM

Guide:
Normal hours of care: Insert the usual arrival time and the usual departure time. Indicate a.m. or p.m.
Normal days of care: Circle the days of the week the participant(s) are usually in attendance at the facility.
(M=Monday; T=Tuesday; W=Wednesday; TH=Thursday, F=Friday,)
Meals Normally Eaten: Circle the meals the participant(s) usually eat at the facility.
(B=Breakfast;; L=Lunch; PM=PM Snack)

Parent/Guardian Signature: _____ Date:_____

Print Name: _____

Home Telephone Number ( ) _____ Work Telephone Number: ( ) _____

For Facility/Provider Use Only:
Signature of Facility Representative/Provider:_____ Date:_____
Date the child withdrew:_____

Updates: (annual at a minimum)	The parent/guardian signing this form certifies that the enrollment information is correct. If information has changed, the parent/guardian has written the appropriate changes on the form and initialed the change. *If there are many changes, please complete a new form.*	
First Update	Parent/Guardian Signature	Date
Second Updated	Parent/Guardian Signature	Date

CHILD DEVELOPMENT CENTER
CHILD HEALTH ASSESSMENT FORM

To be completed within 6 weeks after the child begins the program, and at least annually thereafter, to show the child is current for routine screening tests/preventive health services and immunizations according to the schedule recommended by the American Academy of Pediatrics, the Centers for Disease Control and Prevention, and the Academy of Family Practice.

FOR OFFICIAL USE ONLY. This form may contain personal medical information protected by the Privacy Act of 1974 (see AFI 33-332) and the Health Insurance Portability and Accountability Act (HIPPA) (see DoD 6025.18-R) not intended for disclosure outside government channels and exempt from mandatory disclosure under the Freedom of Information Act, 5 U.S.C., 552. Exemption 6 may apply. Title 5, U.S.C. 552a, The Privacy Act of 1974, as amended, which affords individuals the right to privacy in records maintained and used by Federal agencies. NOTE: 5 U.S.C. 552a includes Public Law (PL) 100-503, The Computer Matching and Privacy Act of 1988.

PART A: TO BE COMPLETED BY THE CHILD'S SPONSOR

CHILD'S NAME: Last, First, MI.	DATE OF BIRTH: MM/DD/YYYY
SPONSOR'S NAME: Last, First, MI.	GENDER: (circle) Male or Female

Note: Immunization information is maintained at the Program in child's records

Health history and medical information pertinent to routine child care and emergencies (describe, if any): ☐ None			Allergies: ☐ None	
Is the above mentioned child covered by TRICARE for health emergencies?	Y	N		
Does the above mentioned child have health and accident insurance other than TRICARE?	Y	N	Insurance Carrier	Policy/Group#

I give permission for the authorized personnel at the

_____

Child Development Center to have access to my child's health assessment information necessary for child care (to include this form).

Sponsor's Signature:	Date:

PART B: TO BE COMPLETED BY THE CHILD'S HEALTH CARE PROVIDER

HEALTH PROBLEMS OR SPECIAL NEEDS, RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE: (e.g., asthma, chronic illness, hearing or vision impairments, feeding needs, neuromuscular conditions, urinary or other ongoing health problems. (Attach additional documentation if necessary)

☐ None

HEALTH CARE PROVIDER'S STATEMENT: I have examined the above named child and/or reviewed their records and find that he/she is current for age-appropriate routine screenings, immunizations and medically able to participate in the program.

NAME OF MEDICAL CARE PROVIDER:	SIGNATURE OF MEDICAL CARE PROVIDER:	
ADDRESS:	PHONE:	DATE FORM SIGNED:

AIR FORCE YOUTH FLIGHT PROGRAM PATRON REGISTRATION

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 8013; 44 USC 3101; EO 9397
PRINCIPAL PURPOSES: To provide Youth Flight Programs with authorization for medical treatment in emergency situations; authorization for field trips; identify children and sponsor, record required immunizations; record known allergies; record income data; record special needs requirements; and record special instructions.
ROUTINE USES: Form may be furnished to civilian doctors or hospitals in course of obtaining emergency medical attention for children. Information furnished may be disclosed, upon request, to other Federal, state or local governmental agencies in the pursuit of their official duties. Finally, it may be used for other lawful purposes including law enforcement and litigation.
DISCLOSURE IS VOLUNTARY: Failure to furnish information, including SSN, will result in denial of admission of child(ren) to Youth Flight Programs. SSN is used for positive identification of individuals and records.

CHILD'S NAME	SPONSOR*(Last, First, Middle Initial)*	SPOUSE*(Last, First, Middle Initial)*	FEES
HOME PHONE	RANK/GRADE	RANK/GRADE	DEROS/ID EXPIRES
ADDRESS	DUTY PHONE	DUTY PHONE	BRANCH OF SERVICE
	ORGANIZATION	EMERGENCY CONTACT	EMERGENCY PHONE
MARITAL STATUS	SPONSOR'S SSN	SPOUSE'S SSN	HOSPITAL PHONE
			PHYSICIAN'S NAME

VACCINE / DATE RECEIVED	BIRTH	2 MOS	4 MOS	6 MOS	12 MOS	15 MOS	18 MOS	4-6 YRS	11-12 YRS	14-16 YRS
Hepatitis B										
1st	Hep B-1									
2nd										
3rd		Hep B-2		Hep B-3					Hep B	
4th										
Diphtheria-Tetanus, Pertussis										
1st										
2nd										
3rd		DTP	DTP	DTIP	DTP			DTP OR DTAP	Td	
4th										
5th										
6th										
H.Influenzane type b										
1st										
2nd										
3rd		Hib	Hib	Hib	Hib					
4th										
Polio										
1st										
2nd										
3rd		OPV	OPV	OPV				OPV		
4th										
Measles, Mumps, Rubella										
1st					MMR			MMR OR MMR		
2nd										
Varicella Zoster Virus Vaccine										
1st						VZV			VZV	
2nd										

SEX *(X One)* ☐ MALE ☐ FEMALE

DATE OF BIRTH (Day, Month, Year)

I authorize emergency treatment for the children named hereon:

SIGNATURE

DATE (YYYYMMDD)

SPECIAL INSTRUCTIONS

SPECIAL NEEDS CARE /CHRONIC ILLNESSES /ALLERGIES

OTHER IMMUNIZATIONS AS REQUIRED:

VACCINE TYPE:	DATE:
VACCINE TYPE:	DATE:
VACCINE TYPE:	DATE:
VACCINE TYPE:	DATE:

NAMES OF ADDITIONAL CHILDREN ENROLLED IN PROGRAM:

ADULTS AUTHORIZED TO SIGN CHILDREN IN / OUT

AUTHORIZATION FOR FIELD TRIPS

FAMILY INCOME *(Adjusted gross--most recent 1040)*
PROVIDE ONLY IF REDUCED FEES ARE REQUESTED.
$_____ SINGLE / DUAL INCOME *(Circle One)* $_____

PARENT SIGNATURE

IT IS THE RESPONSIBILITY OF EACH SPONSOR TO ENSURE IMMUNIZATIONS AND EMERGENCY INFORMATION IS UP TO DATE. FAILURE TO UPDATE MAY RESULT IN REFUSAL OF SERVICE.