

CHILD AND YOUTH SERVICES REGISTRATION FORM

AR 608-10

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, United States Code, Section 3013

PRINCIPAL PURPOSE: To provide child and family program eligibility and background information; sponsor consent for access, to emergency medical care; data required by USDA Food Program.

ROUTINE USES: Information is furnished to the attending physician when it is necessary for a child to be taken to a medical facility by someone other than the parent. Information immunization and medical problems will be used as part of the program admission screening procedure. Family income data will be used to determine USDA Food Program qualification and rate structures.

DISCLOSURE: Disclosure of requested information is voluntary, however, if information is not provided, individual(s) may not be allowed to participate in Child Youth Services (CYS) programs.

DECLARATION OF NONDISCRIMINATION

Services will be made available to all children in attendance, without regard to race, color, religion, nation origin, ancestry, or sex, within the limits of AR 608-10/AR 215-1. CYS programs participating in the USDA Food Program shall offer meals without physical segregation of, or discrimination against any child regardless of ability to pay.

Sponsor's Name:

Date:

Sponsor's SSN:

Membership Date:

Home Address:

Home Phone:

Cell Phone:

Beeper:

On Post Housing Off Post Housing Dual Military Single

I will furnish CYS a copy of my **Family Care Plan** within 30 days of this registration,

Due:

Signature:

Family Size:

Unit/Employer Name & Address:

Work Phone:

Status Active Retired Civilian

Grade/Rank:

Branch:

Spouse's Name:

Spouse's SSN:

Home Address:

Home Phone:

Cell Phone:

Beeper:

Unit/Employer Name & Address:

Work Phone:

Status Active Retired Civilian Unemploye

Grade/Rank:

Branch:

Emergency Notification Designee	Home Phone	Work Phone	Child Release Designee yes/no

Child's Name:

Date of Birth:

Sex:

SSN:

Physical Exam Date:

Special Need:

Medication:

Program Enrolled:

Location:

Grade in School:

Immunization Dates					
DPT					
HEP B					
HIB					
OPV					
MMR					

Child's Name:

Date of Birth:

Sex:

SSN:

Physical Exam Date:

Special Need:

Medication:

Program Enrolled:

Location:

Grade in School:

Immunization Dates					
DPT					
HEP B					
HIB					
OPV					
MMR					

Child's Name:

Date of Birth:

Sex:

SSN:

Physical Exam Date:

Special Need:

Medication:

Program Enrolled:

Location:

Grade in School:

Immunization Dates					
DPT					
HEP B					
HIB					
OPV					
MMR					

I, _____ parent/guardian of

consent to the following in reference to the care of my child/children.

Use of photographs for release to media.

Participation in on-off post excursions accompanied by CYS personnel.

Transportation in a government or commercial vehicle.

Transportation in a private vehicle.

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

I, _____ parent/guardian of

give consent for an authorized CYS representative to take my child/children for care, medical or dental, in an emergency situation where the child's condition represents a serious or imminent threat to his/her life, health, well being. I understand that a conscientious effort will be made to notify me prior to such action and the expense, if any, will be borne by me. Treatment at an Army medical facility may be provided without additional consent under the provision of AR 40-3, paragraph 2-24b.

Signature _____

Date _____