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JBSA CHILD AND YOUTH PROGRAMS

HEALTH SCREENING

PRIVACY ACT STATEMENT

PRINCIPAL PURPOSE: Information will be used to assist CYP activities in their responsibilities in overall execution of the Multidisciplinary Inclusion Action Team functions.

DISCLOSURE: Disclosure of requested information is voluntary; however, if information is not provided individual may not be able to participate in Air Force Child and Youth Programs.

FOR REGISTRATION PERSONNEL: *CHECK ALL THAT APPLY*

Initial Registration **Re-registration** **Change in Condition** **On waiting list** **Date care needed? _____**

PART A: GENERAL INFORMATION (*PARENT COMPLETES THE REMAINDER OF THE FORM)*

Child/Youth's Name	Child/Youth School Grade (example: 3rd Grade)	Date of Birth (*MMDDYYYY*)	Age

Type of Program Requested: (*check all that apply)*

CDC **Full Time** **Hourly Care** **SAC** **Youth Program** **Sports** **Instructional Classes**

Other:

Sponsor Name	Sponsor Email (*AKO*)	
Spouse Name	Spouse Email	
Cell Phone	Sponsor Duty Phone	Sponsor Unit

PART B: CHILD/YOUTH MEDICAL/DEVELOPMENTAL CONDITIONS (*CHECK YES OR NO)*

Does your child/youth have:	Yes	No		Yes	No
1. Any hospitalizations or operations			15. Developmental disability		
2. Asthma/Reactive Airway Disease/Breathing Condition			16. Learning concerns		
a. Does it require a rescue medication?			17. Physical disability		
3. Allergies (food, insect, medication)			18 Sleeping concerns		
a. Does it require a rescue medication?			19. Visual problems not corrected by glasses/contacts		
4. Dietary Restrictions a. Medically-based			20. Hearing deficit/difficulties		
b. Religiously-based			21. Speech/language concerns		
5. Feeding or swallowing problem			22. Dental or orthodontic braces		
6. Diabetes			23. Broken bones or sprains		
7. Epilepsy/Seizures			24. Headaches		
8. Complicated or Premature Birth in the last year			25. Neck or back injury		
9. Cancer			26. Blood pressure or Heart conditions		
10. Asperger's Syndrome			27. Chest pain with exercise		
11. Autism Spectrum Disorder			28. Dizziness or fainting with exercise		
12. Emotional problems/difficulties			29. Other Medical conditions or concerns		
13. Diagnosed Behavior/Conduct concerns			If yes, please explain:		
a. Is your child/youth prescribed medications?					
14. Attention Deficit/Hyperactivity Disorder (ADD/ADHD)?					
a. Is your child/youth prescribed medication?					

Version 6 Approved by JBSA, CYP Flight Chief, July 2016

HEALTH SCREENING

Child's/Youth's Name:	DOB:

PART C: MEDICATIONS

List any medications that are prescribed for your child/youth:

Medication Name	Dosage	Frequency	Must be given in Care

PART D : EARLY INTERVENTION AND SPECIAL EDUCATION

Does your child/youth receive special services/therapies?
☐ Yes ☐ No
If yes, please specify:

Does your child/youth have an:

a. Individualized Education Plan (IEP) ☐ Yes ☐ No

b. Individualized Family Service Plan (IFSP) ☐ Yes ☐ No

c. 504 Plan ☐ Yes ☐ No

PART E : EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) ENROLLMENT

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

Child and Youth Programs strive 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 status please notify CYP Director immediately.

PART F- RELEASE OF INFORMATION

I authorize _____ to release any medical information regarding my child
(N*ame of Medical Treatment Facility or Physician's Practice)*
_____ to the _____
(*name of child)* **(*name of installation)***

Child and Youth Programs (CYP) Multidisciplinary Inclusion Action Team (MIAT) personnel that are necessary to conduct MIAT 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 MIAT team 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 rediscolure. I understand that information re-disclosed 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 of Parent/Personal Representative of Child/Youth	Signature of Parent/Personal Representative of Child/Youth	Date *(MMDDYYYY)*
Please provide the following information to help locate the electronic medical record:	**Sponsors SSN (Last 4 digits)**	**Sponsors DOB:**