

CHILD AND YOUTH SERVICES REGISTRATION ADDENDUM FORM (Revised)
(TO BE COMPLETED WHEN REGISTERING MORE THAN THREE CHILDREN IN THE SAME FAMILY)

NAME OF SPONSOR (LAST, FIRST) _____ SSN _____

NAME OF CHILD/YOUTH _____ DOB _____ AGE _____ SEX _____

CHICKEN POX	YES <input type="checkbox"/>	NO <input type="checkbox"/>	ORTHOPEDIC PROBLEMS	YES <input type="checkbox"/>	NO <input type="checkbox"/>
SCARLET FEVER	YES <input type="checkbox"/>	NO <input type="checkbox"/>	HEARING PROBLEMS	YES <input type="checkbox"/>	NO <input type="checkbox"/>
DIABETES	YES <input type="checkbox"/>	NO <input type="checkbox"/>	SEIZURE DISORDER	YES <input type="checkbox"/>	NO <input type="checkbox"/>
RHEUMATIC FEVER	YES <input type="checkbox"/>	NO <input type="checkbox"/>	VISION PROBLEMS	YES <input type="checkbox"/>	NO <input type="checkbox"/> IF YES, CHECK IF CORRECTED BY GLASSES <input type="checkbox"/>
ASTHMA	YES <input type="checkbox"/>	NO <input type="checkbox"/>	ENROLLED IN EFMP	YES <input type="checkbox"/>	NO <input type="checkbox"/> IF YES, REASON: _____

ANY MEDICAL PROBLEMS OR ALLERGIES NOT LISTED ABOVE: _____
CHILDREN/YOUTH WITH SPECIAL DIET REQUIREMENTS MUST HAVE THE COMPLETED "SPECIAL DIET STATEMENT" AS PART OF THEIR FILE WITHIN 30 DAYS OF REGISTERING. MEDICAL RECORDS LOCATED AT: _____

IMMUNIZATIONS

(TO BE COMPLETED BY SHOT RECORDS CLERK) CLERK: _____

HEP-B	_____	_____	_____	_____	_____	REGISTRATION RENEWAL: PARENTS INITIALS INDICATE CHILD'S HEALTH IS THE SAME AS WHEN THE HEALTH ASSESSMENT WAS COMPLETED. PARENT _____ RENEWAL DATE _____ RENEWAL CLERK _____ _____ _____ _____
DPT	_____	_____	_____	_____	_____	
HIB	_____	_____	_____	_____	_____	
OPV/IPV	_____	_____	_____	_____	_____	
MMR	_____	_____	_____	_____	_____	
TB	_____	_____	_____	_____	_____	
VARICELLA/VARIVAX	_____	_____	_____	_____	_____	_____

HEALTH ASSESSMENT MADE ON: _____

PROGRAM INFO (TO BE COMPLETED BY CLERK)

FULL DAY AT _____ PART DAY AT _____ FCC HC CAMP AT _____
 YC AT _____ SAS AT _____ OTHER _____

NAME OF CHILD/YOUTH _____ DOB _____ AGE _____ SEX _____

CHICKEN POX	YES <input type="checkbox"/>	NO <input type="checkbox"/>	ORTHOPEDIC PROBLEMS	YES <input type="checkbox"/>	NO <input type="checkbox"/>
SCARLET FEVER	YES <input type="checkbox"/>	NO <input type="checkbox"/>	HEARING PROBLEMS	YES <input type="checkbox"/>	NO <input type="checkbox"/>
DIABETES	YES <input type="checkbox"/>	NO <input type="checkbox"/>	SEIZURE DISORDER	YES <input type="checkbox"/>	NO <input type="checkbox"/>
RHEUMATIC FEVER	YES <input type="checkbox"/>	NO <input type="checkbox"/>	VISION PROBLEMS	YES <input type="checkbox"/>	NO <input type="checkbox"/> IF YES, CHECK IF CORRECTED BY GLASSES <input type="checkbox"/>
ASTHMA	YES <input type="checkbox"/>	NO <input type="checkbox"/>	ENROLLED IN EFMP	YES <input type="checkbox"/>	NO <input type="checkbox"/> IF YES, REASON: _____

ANY MEDICAL PROBLEMS OR ALLERGIES NOT LISTED ABOVE: _____
CHILDREN/YOUTH WITH SPECIAL DIET REQUIREMENTS MUST HAVE THE COMPLETED "SPECIAL DIET STATEMENT" AS PART OF THEIR FILE WITHIN 30 DAYS OF REGISTERING. MEDICAL RECORDS LOCATED AT: _____

IMMUNIZATIONS

(TO BE COMPLETED BY SHOT RECORDS CLERK) CLERK: _____

HEP-B	_____	_____	_____	_____	_____	REGISTRATION RENEWAL: PARENTS INITIALS INDICATE CHILD'S HEALTH IS THE SAME AS WHEN THE HEALTH ASSESSMENT WAS COMPLETED. PARENT _____ RENEWAL DATE _____ RENEWAL CLERK _____ _____ _____ _____
DPT	_____	_____	_____	_____	_____	
HIB	_____	_____	_____	_____	_____	
OPV/IPV	_____	_____	_____	_____	_____	
MMR	_____	_____	_____	_____	_____	
TB	_____	_____	_____	_____	_____	
VARICELLA/VARIVAX	_____	_____	_____	_____	_____	_____

HEALTH ASSESSMENT MADE ON: _____ (DATE) BY _____ (MEDICAL PERSONNEL).

PROGRAM INFO (TO BE COMPLETED BY CLERK)

FULL DAY AT _____ PART DAY AT _____ FCC HC CAMP AT _____
 YC AT _____ SAS AT _____ OTHER _____