

Receipt No. _____

Registration Expiration Date _____

Registration Site _____ by _____ (CYS STAFF)

ID Expiration Date _____

CHILD AND YOUTH REGISTRATION INFORMATION FORT HOOD, TEXAS

PRIVACY ACT STATEMENT: AUTHORITY: Title 10, United States Code, Section 3012. PRINCIPAL PURPOSE: To verify child/youth and family eligibility and background information, obtain parental consent for access to emergency medical care, obtain data required by USDA food program, verify child/youth health status and currency of immunizations per admission requirements, note any special program considerations or restricted on child/youth participation, refer child/youth for enrollment in Exceptional Family Member Program (EFMP) DISCLOSURE: Disclosure of requested information is voluntary; however, if information is not provided, individuals may not be able to participate in child/youth programs and services.

DECLARATION OF NONDISCRIMINATION Services will be made available to all children/youth in attendance without regard to race, color, religion, national origin, ancestry, or sex. CDS/SAS programs participating in the USDA food program shall offer meals without physical segregation of, or discrimination against any child/youth regardless of ability to pay.

NAME OF SPONSOR (LAST, FIRST) _____ RANK _____ SSN _____

DUTY ADDRESS _____ DUTY PHONE _____

HOME ADDRESS _____ HOME PHONE _____

CITY/STATE/ZIP CODE _____ ON-POST VILLAGE _____

NAME OF SPOUSE (LAST, FIRST) _____ RANK _____ SSN _____

DUTY/WORK ADDRESS _____ DUTY/WORK PHONE _____

HOME ADDRESS (IF DIFFERENT) _____ HOME PHONE _____

CITY/STATE/ZIP CODE _____

PERMISSION FOR CHILD(REN)/YOUTH TO BE IN PHOTOGRAPHS RELEASED TO MEDIA YES NO

CHILD RELEASE DESIGNEES (Adults, other than parents, living within 30 miles who can pick up the child/youth when parents are not available: not more than one in the sponsor's unit and not more than two in the same family)

NAME	HOME PHONE	DUTY/WORK PHONE OR N/A
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMERGENCY TREATMENT AND HOLD HARMLESS AGREEMENT FOR ALL CHILDREN/YOUTH REGISTERED

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

--If participating in Youth Services activities, permission to participate extends to and includes transportation to, during, and from the activity or event by common carrier, Government or military vehicle, and volunteered private vehicles. For and in consideration of the US Army furnishing and allowing my child's participation in activities and events, I for myself and in my capacity as parent or *in loco parentis*, do hereby covenant and agree that I will not assert any claim nor institute any civil proceeding of any kind against the US Army or any of its officers, agents, or employees on account of injury or death to persons, or loss, damage, or destruction of property which may result from such participation, the use of Government facilities, or the negligence of said officers, agents, or employees. I do further agree, for the same consideration, to hold harmless and to indemnify the US Army, its officers, agents, and employees for any and all judgments which may be awarded against them and for expenses incident to litigation by third parties resulting from such participation, use of Government facilities or negligence of said officers, agents, or employees.

--I affirm that the child(ren)/youth named on this form is(are) physically fit to participate in the activity(ies) for which I have registered him/her/them.

Signature of Sponsor/Parent

Date

SOLE (SINGLE) MILITARY AND DUAL MILITARY PARENTS---FAMILY CARE PLAN INFORMATION FOR LONG-TERM GUARDIAN:
(For parents of children/youth in CDS/SAS, and must be verified within 30 days registration with completed DA-5305 signed by commander)

NAME OF LONG-TERM GUARDIAN _____ STREET ADDRESS _____

WORK PHONE _____ HOME PHONE _____ CITY/STATE/ZIP CODE _____

VERIFIED BY _____ (CYS STAFF) ON _____ (DATE)

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

CHICKEN POX YES NO VISION PROBLEMS YES NO (CHECK HERE IF CORRECTED BY GLASSES)
SCARLET FEVER YES NO ORTHOPEDIC PROBLEMS YES NO
DIABETES YES NO HEARING PROBLEMS YES NO
RHEUMATIC FEVER YES NO SEIZURE DISORDER YES NO
ASTHMA YES NO ENROLLED IN EFMP YES NO 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 CLERK FROM SHOT RECORDS): CLERK: _____ REGISTRATION RENEWAL: PARENT'S INITIALS INDICATE CHILD'S HEALTH IS THE SAME AS WHEN THE HEALTH ASSESSMENT WAS COMPLETED

HEP-B _____ PARENT _____ RENEWAL DATE _____ RENEWAL CLERK _____
DPT _____
HIB _____
OPV/IPV _____
MMR _____ VARICELLA/VARIVAX _____
TB _____

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 (SPECIFY) _____

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

CHICKEN POX YES NO VISION PROBLEMS YES NO (CHECK HERE IF CORRECTED BY GLASSES)
SCARLET FEVER YES NO ORTHOPEDIC PROBLEMS YES NO
DIABETES YES NO HEARING PROBLEMS YES NO
RHEUMATIC FEVER YES NO SEIZURE DISORDER YES NO
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