

# CHILD & YOUTH SERVICES REGISTRATION FORM (AR 608-10)

Child: (Last Name) \_\_\_\_\_ (First) \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

SPONSOR: (Last Name) \_\_\_\_\_ (First) \_\_\_\_\_ SSN: \_\_\_\_\_ e-mail \_\_\_\_\_

SPOUSE: (Last Name) \_\_\_\_\_ (First) \_\_\_\_\_ e-mail \_\_\_\_\_

Home Address: \_\_\_\_\_ Unit Address: \_\_\_\_\_ Phone Number \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Data Required by the Privacy Act of 1974

**Authority:** Title **Principal Purpose (s):** 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 provided to the attending physician when it is necessary for a child to be taken to medical facility by someone other than the parent. Information on immunizations and medical problems will be used for program-admission-screening procedures. Family income data will be used to determine USDA food program qualifications and rate structures.

**Disclosure:** Disclosure of requested information is voluntary. However, if information is not provided, individuals may not be allowed to participate in Child and Youth Services (CYS) programs.

### Declaration of Nondiscrimination

Services will be made available to all children in attendance, without regard to race, color, religion, national origin, ancestry, or gender, within the limits of AR 215-1 and AR 608-10. CYS programs participating in the USDA food program will offer meals without physical segregation of or discrimination against any child regardless of ability.

### Medical Consent

I, \_\_\_\_\_ (parent/guardian) of \_\_\_\_\_ (youth's name) give consent for an authorized CYS representative to take my child for care, medical or dental, in an emergency situation when the child's condition 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 before such action. I will pay any expenses incurred. Treatment at an Army medical facility may be provided without additional consent under the provisions of AR 40-3, paragraph 2-24B.

### Sponsor/Parent Consent

I, \_\_\_\_\_ (parent/guardian) of \_\_\_\_\_ (youth(s) name) consent to the following in reference to the care of my child(ren):

- a. Use of photographs of my child for release to the Installation newspaper, civilian media, or to copyright and/or reuse in other military or civilian publications or on the Installation websites.  Yes  No
- b. I have been offered a copy of the CYS Parent Handbook  Yes  No
- c. I have been offered a copy of the CYS Fee Policy  Yes  No
- d. Transportation in a private/CYS vehicle (in the event of a CYS emergency or FCC if authorized by the parent in writing)  Yes  No
- e. I give my permission for my child to use the computes, network, and internet at the CYS programs in a responsible manner. My child will agree to follow the posted rules put forth by the CYS program and will be held responsible for any violation of these rules. As the sponsor/parent I will convey good standards for internet use to my child. \*For a copy of your center's user agreement on the on line standards, contact the CYS Computer Lab staff.  Yes  No

### Sole and Dual Military Family Care Plan

As prescribed by AR 600-20 and AR 608-10 Military personnel are required to maintain an accurate Family Care Plan which will remain in CYS Central Enrollment Registry. The DA Form 5305-R Family Care Plan must be complete with in 30 days of enrollment or services may be denied. The Family Care Plan information must be updated annually or more frequently in order to maintain accurate information. \_\_\_\_\_ **initial**

**I have reviewed the attached household and family information file. To the best of my knowledge, both the information on this form and the attached CYMS information are accurate and complete.**

**Date:** \_\_\_\_\_ **Signature of Parent/Guardian:** \_\_\_\_\_

Emergency Notification Designee	Home/Cell Phone	Release Designee
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### OFFICE USE

PROGRAM _____	REGISTRATION FORM _____
ROOM _____	USDA INCOME ELIGIBILITY _____
START DATE _____	DOD FEE APPLICATION _____
FEE CATEGORY _____	CYMS PROFILE _____
MONTHLY _____	BI-WEEKLY _____
SPECIAL NEEDS _____	SCREENING ON FILE _____
PROVIDER _____	
SWIPE CARDS ISSUED _____	

### OFFICE USE

Date Due \_\_\_\_\_

Health Assessment \_\_\_\_\_

Family Care Plan \_\_\_\_\_

Shots Due \_\_\_\_\_

Other Due \_\_\_\_\_