SPORTS REGISTRATION PACKET

Attached are the registration documents for completing your child's registration with Youth Sports. Please sign where indicated and return back to us at your earliest convince.

We will also need a current physical within the year, and a print out of a current shot record. ***FLU SHOT IS MANDATORY***

If there are any medical concerns, diagnosis, IEP, or Food allergies, please be prepared for a few additional steps. If there are Medical concerns please follow up for additional information. 703- 805- 5487

Once that is complete you are able to proceed to Webtrac for sign up, dates of registration, and payments.

If you have any addition questions about Practice, Participation, Coaching or Waitlist feel free to contact our sports office at (703) 805 - 1258

Rhonda D. Simpson
Sports & Fitness Admin
Desk: (703) 805-5487
LaRhonda.d.simpson.naf@army.mil

Rashawd Pope
Assistant Director, Youth Sports and Fitness Child & Youth Services
Desk: (703) 805-1257
rashawd.l.pope.naf@army.mil

Aricka Vaughan
Sports Specialist (Youth Sports & Fitness) Child & Youth Services
9500 Barlow Road, Bldg. 950
Desk: (703) 805-1258
aricka.a.vaughan.naf@army.mil

CYS Verification of Employer, DoD Priority and Eligibility

Sponsor Name:	Spouse/Partner Name:
Military Unit: CIV Place of work: DoD Priority: RFT RPT FLX STUDENT UNEMPLOYEE OTHER (Circle One)	Military Unit: CIV Place of work: DoD Priority: RFT RPT FLX STUDENT UNEMPLOYEE OTHER (Circle One)
Official Email: Civilian Email:	Official Email: Civilian Email:
ID CAC Expiration Date: Rank:	ID CAC Expiration Date: Rank:
Cell Number/Provider	Cell Numer/Provider:
Eligibility Verification (Circle One) Birth Certificate, DEERS Form or Dependent ID	Eligibility Verified by:
(Birth Certificate copy needed for Youth Sport-Specifically for Track and Wrestling)	Eligibility Witness by:

EMERGENCY CONTACTS

Name:		
Relationship:		
Phone Number:		
Allow to pick- up circle	YES	NO

Name:		
Relationship:		
Phone Number:		
Allow to pick- up circle	YES	NO

Name:		
Relationship:		
Phone Number:		
Allow to pick- up circle	YES	NO

ARMY CHILD AND YOUTH SERVICES HEALTH SCREENING – TOOL #1

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 3013, Secretary of the Army; 29 U.S.C. 794, Nondiscrimination Under Federal Grants and Programs, DoDD 1342.17 Family Policy; AR 608-75, Exceptional Family Member Program: AR 608-10, Child Development Services; and E.O. 9397 (SSN).

PRINCIPAL PURPOSE: Information will be used to assist Army activities in their responsibilities in overall execution of the Army's Exceptional Family member Program (EFMP) and the Army Child and Youth Services Program.

ROUTINE USES: The DoD "Blanket Routine Uses" that appear at the beginning of the Army's compilation of systems of records apply to this system

DISCLOSURE: Disclosure of requested information is voluntary; however; if information is not provided individual may not be able to participate in Army Child and Youth Services Program.

SNAP Case Number: ________________

FOR CER COMPLETION ONLY

□ Initial Registration Is child on waiting list? □ Yes □ No Date care needed? ________________ □ Re-registration/Child Already in Program □ Change in Program	**Date in from Patron:** **Date out to APHN:**

Part A – General Information

Child/Youth Name	Child/Youth School Grade (example: 3rd Grade)	Date of Birth (YYYYMMDD)	Age

Type of Placement Requested: (check all that apply)
□ Hourly Care □ Full Day Care □ Middle School/Teen Program □ Summer Camp □ Other: (specify)
□ Part Day Care □ Before/After School Care □ SKIES/Instructional Classes □ Sports

Sponsor Name	Sponsor E-mail	Best Contact Number
Spouse Name	Spouse E-mail	
Home Phone	Cell Phone	Sponsor Unit
Home Address		Sponsor Duty Phone

Part B – Identification of Child/Youth Condition/Restrictions

Does you child have any of the following conditions/restrictions: (check no or yes and answer questions as appropriate)

1. Allergies
   a. Life threatening reaction? □ No □ Yes
   b. Rescue Medication (Epi-pen, Benadryl, Inhaler) □ No □ Yes
   c. Does child/youth need rescue inhaler? □ No □ Yes
   If your child/youth has an allergy, please list: ____________________________
   ____
   Reaction: ____
   ____
2. Special Diet □ No □ Yes
   a. Is your child on a complex diet (i.e. gluten free, diabetic) □ No □ Yes
   b. Does your child have a food intolerance/mild food allergy (i.e. rash from strawberries/milk intolerance)? □ No □ Yes
   c. Does your child have a dietary religious restriction? □ No □ Yes
3. Asthma/Reactive Airway Disease/Breathing Problems? □ No □ Yes
   a. Does your child need a rescue med? □ No □ Yes
4. Does your child have diabetes? □ No □ Yes
5. Does your child have seizures? □ No □ Yes
6. Attention Deficit Disorder (ADD/ADHD)
   a. Are there behavior/conduct concerns while on meds? □ No □ Yes
   b. List ADD/ADHD medications: ____________________________________
   ____
   ____
   ____
7. Behavior/ conduct concerns (oppositional defiant disorder, anxiety, depression, bipolar, other)? □ No □ Yes
8. Autism Spectrum Disorders (Autism, Aspergers, Rett Syndrome, PDD-NOS) □ No □ Yes
9. Does your child have any of the following health concerns? (circle all that apply)- Hearing impairment, vision impairment other than corrective lenses, heart, kidney, physical disability SEVERE skin condition □ No □ Yes
   Please specify ____
   ____
10. Does your child have a speech/language and/or hearing loss that affects their ability to communicate their basic needs (hurt, bathroom, fear, thirst)? □ No □ Yes
    Explain: ____
    ____
    ____
11. Does your child have developmental delays other than MILD speech language/MILD hearing loss? □ No □ Yes
    Explain: ____
    ____
12. Are there any other conditions or concerns that you would Like staff to be aware of? □ No □ Yes
    Explain: ____

Part C – Medications

List any medications that are prescribed for your child/youth other than those listed above:

Will your child require medication administration during child care/youth supervision hours? □ No □ Yes

Part D – Early Intervention and Special Education

Does your child/youth receive special services/therapies? □ No □ Yes
Please specify: ____

Does your child/youth have an Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP) or 504 Plan? □ No □ Yes

Part E – Exceptional Family Member Program (EFMP) Enrollment

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

____ ____________________________
Printed Name and Signature of Parent/Personal Representative of Child/Youth Date (YYYYMMDD)

If you have answered NO to all the questions above you are now finished with this form.
Please sign and date indicating that the information above is accurate and complete to the best of your knowledge.

Child, Youth and School Services strives 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 please notify CYS Services immediately.

If you answered YES to any of the questions above, complete Part F on the next page.

Child/Youth Name	Date of birth (YYYYMMDD)	Age

Part F – Release of Information

I authorize ____________________________________(name of Medical Treatment Facility or physician's practice) to release any medical information regarding my child __________________________(name of child) to the ____________________________ (name of installation) Child & Youth Services (CYS) Special Needs Accommodation Process (SNAP) personnel and their staff that is necessary to conduct SNAP 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 SNAP 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 redisclosure. I understand that information redisclosed 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 and Signature of Parent/Personal Representative of Child   Date (YYYYMMDD)

Part G – Army Public Health Nurse (APHN) Review

Current Medications other than those listed on page 1:

Diagnosis: _________________________

Background/Notes:

Medical Records Reviewed? ◻ No ◻ Yes ◻ Not Available

Training for CYS Staff/Provider Required:

Recommendation Summary:

SNAP REQUIRED: ◻ No SNAP required ◻ Modified ◻ Full ◻ Annual Review (No team meeting required)

Requirements Prior to Placement:

Medical Action Plan reviewed by APHN: ◻ Respiratory ◻ Allergy ◻ Seizure ◻ Diabetes ◻ Special Diet ◻ Other___________________

APHN Printed Name or Stamp	APHN Signature	Date (YYYYMMDD)

Date Received by APHN	Date Returned to CER:

HEALTH ASSESSMENT/SPORTS PHYSICAL STATEMENT (HASPS)
for CYS SERVICES
ENROLLMENT, Renewal & SPORTS PHYSICAL Requirements

Revised 08Jan 09

DATA REQUIRED BY THE PRIVACY ACT OF 1994

PRINCIPAL PURPOSE: Information is used by DA personnel to: (1) verify child health status of immunization per admission requirements; (2) note special program considerations or restriction on child participation; (3) execute emergency medical procedure for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program; (5) certify physically fit to participate in sports. **ROUTINE USES:** No information is disclosed outside DOD. **DISCLOSURE:** Information is voluntary; however, if information is not provided, individuals may not be able to participate in community activities.

INSTRUCTIONS: All sections A, B, C. must be completed

PART: A Medical History (Filled out by parent / guardian)

Name of Sponsor	Home Telephone Cell Telephone	Duty/Work Telephone
Sponsor Unit / Work Address		Spouse's Work Telephone

CHILD HEALTH INFORMATION

Name of Child	Birth Date	Sex ☐ Male ☐ Female

Does your child have ongoing medical concerns?
(If Yes, explain circumstances and current status)

☐ Yes ☐ No

Is your child enrolled in Exceptional Family Member Program?
(If Yes, explain)

☐ Yes ☐ No

MEDICAL HISTORY

	YES	NO		YES	NO
1. Any hospitalization or operations			14. Heat stroke or exhaustion		
2. Allergies to medicine, insect bites or food			15. Broken bones or sprains		
3. Speech or development delays			16. Joint injuries (Ankle/Knee/Wrist)		
4. Vision Problems (Glasses / Contacts)			17. Required restricted physical activity		
5. Ear or hearing problems			18. Diabetes		
6. Seizures or Convulsions			19. Cancer		
7. Dizziness or fainting with exercise			20. Dental or orthodontic braces		
8. Headaches			21. Learning problems		
9. Head injury or loss of consciousness			22. Sleep problems		
10. Neck or back injury			23. Behavioral problems		
11. Asthma or difficulty breathing			24. ADD / ADHD		
12. Heart or blood pressure problems			25. Autism Spectrum Disorder		
13. Chest pain with exercise			26. Other (please list below)		

If you answer yes to any of the above, please explain:

Ongoing Medications

Name	Dosage	Frequency

Allergies – All Types (Foods, Medicines and Insect Bites)

Type	Reaction

PART B: Physical Exam

Medical Staff Assessment (Completed by licensed independent practitioner: Doctor-Dr., Nurse Practitioner-NP, Physician's Assistant-PA)

Age YRS MOS	**Height** __________ cm. (_____ %ile)	**Weight** __________ kgs. (_____ %ile)
BP: / **P:**	**Visual Acuity** Right / Left / Tested with / without glasses	

	NORMAL	ABNORMAL	N / A	COMMENTS
1. Eyes				
2. Ears, Nose & Throat				
3. Hearing				
4. Mouth & Teeth				
5. Neck (Soft tissues)				
6. Cardiovascular				
7. Chest & Lungs				
8. Abdomen				
9. Genitalia – Hernia				
10. Skin & Lymphatics				
11. Spine – Scoliosis				
12. Extremities				
13. Neurological				
14. Wears braces / plates				

Based on this HX and PX exam, the following abnormalities were found and may need treatment:

Immunizations are current and up to date: ☐ Yes ☐ No

PARTICIPATION RECOMMENDATIONS

☐ All sports _____Yes _____ No

☐ Normal physical activity to including PE

☐ Additional comments:

☐ Restrictions:

Sports Physical is valid for 1 year from date indicated below

PART C

Special Medical Considerations: Describe any special program needs, considerations or restrictions which the child requires in order to participate in CYS programs (to include Sports).

Child / Youth is able to participate in normal CYS programs? ☐ Yes ☐ No

Date	Licensed Health Care Professional Stamp	Licensed Health Care Professional; Dr., NP or PA Signature

Initial Date	Type or print name of Parent or Guardian	Signature of Parent or Guardian

HASPS Renewal (Not Part of the Sports Physical)

Year 2 Date	Health Status Changed	Signature of Parent or Guardian
	☐ Yes ☐ No	

Year 3 Date	Health Status Changed	Signature of Parent or Guardian
	☐ Yes ☐ No	

U.S. Army Child, Youth & School Services

Child, Youth & School Services
Youth Sports & Fitness Registration Parents' Code of Conduct

I will encourage good sportsmanship by demonstrating positive support for all players, coaches and officials at every game, practice or other sports event. I will place the emotional and physical well-being of my child ahead of a personal desire to win. I will support coaches and officials working with my child, in order to encourage a positive and enjoyable experience for all. I will demand a sports environment for my child that is free of drugs, tobacco and alcohol. I will remember that the game is for youth—not adults. I will do my very best to make youth sports fun for my child. I will expect my child and other household members to treat other players, coaches, fans and officials with respect.

In order to foster quality and timely communication in the event that I or my child/youth has a technical or administrative issue or concern, I will follow the process noted below.

- First Step: Ask the Coach (technical issues) and/or the Team Manager (administrative issues). Often this is the fastest way to get issues taken care of. Please wait 24 hours before contacting the coach after practice or a game. Set up an appointment to speak with the coach personally or over the phone. A coach should not be approached on the practice or game field.

- First Level of Escalation: If I need to go further, I will contact the appropriate Commissioner for my child's sport or program.

- Second Level of Escalation: If working with the Coach and the Commissioner fails to answer my questions or concerns I will then contact a member of the Youth Sports & Fitness Team.

The undersigned agrees to indemnify and will hold harmless the Morale, Welfare and Recreation (MWR) fund from any and all costs, charges, claims, demand and liabilities of any kind arising from improper negligent use of, participation in, or involvement with MWR facilities, equipment, services or programs.

Statement of Understanding
Regarding the Administration of Medication at Youth Sports & Fitness Events

I, ________________________________, understand that the administration of medication for my child is my responsibility and that the Child, Youth & School Services staff, including coaches, is NOT authorized to administer medication. In the event that my child is in need of medication, it is my responsibility to be on-site at all games and practices to hold and administer the medication or to ensure another responsible adult is able to hold and administer the medication in my absence.

I will remain considerate of children participating in the programs with food allergies to include but not limited to peanuts. Reactions to food allergies can be severe and life threatening.

____ ____________________

Parent Signature Date

Revised January 2015

Why are SNAPs important?

The Special Needs Accommodation Team is a multidisciplinary team established to ensure the most appropriate identification and placement of children and youth with special needs in the Child and Youth School Services. CYS Services strives to provide a safe and enriching environment for children. They need to know who has a medical condition, functional limitation or behavioral-psychological condition so that they can ensure that these children (and the other children in the CYS Services programs) are safe from harm, and that their needs are being met.

What happens during a SNAP meeting?

During a SNAP meeting, parents, the EFMP manager, the Army Public Health Nurse, the CYS Services Chief, CYS Services program staff representatives and others who may be requested by the parent(s) to attend the SNAP. They each give their input about the child's special needs and of how they feel the child can be accommodated for within the CYS Services program. A plan is decided upon which the CYS Services Chief and the parent(s) sign in agreement to.

CYS Services staff might receive training from specialists in the community covering topics such as interacting with Autistic children, communicating with children who have limited language skills and administering an Epi-pen. CYS Services programs post food allergies, and in some cases they might not allow a food in the program (such as peanut products).

*Note: upon completion of the SNAP, the request for care process will continue and is based on the original wait list application date. Parents are only offered a space in care if one is available.

Who is an Exceptional Family Member?

The Army defines an EFM as any Family member, regardless of age, who has a diagnosis which limits that individual's ability to function on a daily basis and requires ongoing counseling, training, education, therapy or treatment.

How do you enroll in EFMP?

The EFMP is a mandatory enrollment program for Family members of active duty Soldiers with any medical, educational or learning disability requiring special medical treatment, education, or counseling. To enroll in EFMP, the Soldier contacts the nearest Army medical treatment facility EFMP point of contact to initiate the assessment process and obtain the enrollment forms.

The Army will consider the special needs of enrolled EFMs during the assignment process and will attempt to assign the Soldier to an area where the needs of the Family member can be met.

For more information regarding EFMP, the SNAP or other related community resources, contact the Exceptional Family Member Program Manager at Army Community Service, Fort Belvoir, VA at 703-805-4418.

EFMP

Fort Belvoir, VA 22060
703-805-4418

SNAP

Special Needs Accommodation Process

Who may be referred to the SNAP?

If a parent answers "yes" to any question on the DA Form 7625-1 during CYS Services registration, the Army Public Health Nurse (APHN) determines if the child has any condition, functional limitation or behavior/psychological condition which would require a SNAP. The SNAP takes place prior to the child attending a CYS Services program.

Parents are responsible for providing all requested/required medical information to APHN for review before child placement is determined. Failure to provide requested information may result in a delay in the child being placed. Children will not be allowed to start in CYS Services until the review is completed.

Examples of conditions requiring a SNAP:

- Asthma
- ADD/ADHD
- Allergies
- Autism
- Bleeding Disorder
- Cancer
- Cerebral Palsy
- Cystic Fibrosis
- Diabetes
- Down Syndrome
- Epilepsy
- Heart Problems
- Sickle Cell Anemia
- Hearing Impairment
- Speech Problems
- Limited Mobility
- Learning Disorders/Disabilities
- Development Delays
- Behavior or Social Conduct Concerns
- Bi-Polar or Manic Depressive Disorders
- Bladder or Bowel Problems
- Bone, joint, or Muscle Concerns
- Head or Spinal Injury/Problems
- Skin Problems
- Surgery
- Visual Problems

What is a SNAP?

The Special Needs Accommodation Process (SNAP) is a meeting with the Army Community Services (ACS) Exceptional Family Member Program (EFMP) Coordinator, the CYS Services Chief, the Army Public Health Nurse, and the parent who has requested that their child be placed in a CYS Services program. The purpose of the meeting is to determine how CYS Services can best meet the needs and to ensure the safest and most appropriate place for each child within the CYS Services program system.

Where and when is the SNAP held?

SNAP meetings are scheduled as quickly as possible and are normally held on the first and third Wednesday of each month at Sosa Building: 9800 Belvoir Road Bldg. 200.

Parents with children going through the SNAP are highly encouraged to attend.

EFMP
Fort Belvoir, VA 22060
703-805-4418

IMCOM G9 Child and Youth Services
Immunization Waiver Request Form

☐ Initial
☐ Renewal

☐ Non-Medical request
☐ Medical request

Child/Youth/Staff/Volunteer/Contractor ☐ ☐ ☐ ☐ **Full Name (Last, First, Middle):**	**Age:** ____________ **Date of Birth:** **Program Attend/Work:**
Installation:	**Staff/Volunteer/Contractor Position:**

Waiver for Medical/ Non-Medical Circumstance

The identified person requests an Immunization Waiver. They have a medical/non-medical circumstance preventing administrations of required immunizations for participation in CYS programs.

☐ Medical Diagnosis (Medical Provider signature and Stamp required):

____
____
____

Immunization	**Duration of physical condition**	
☐ DTaP	☐ Temporary until Date:___________	☐ Permanent
☐ Influenza	☐ Temporary until Date:___________	☐ Permanent
☐ MMR	☐ Temporary until Date:___________	☐ Permanent
☐ Tdap	☐ Temporary until Date:___________	☐ Permanent
☐ Varicella	☐ Temporary until Date:___________	☐ Permanent
☐ Other	☐ Temporary until Date:___________	☐ Permanent
☐ Other	☐ Temporary until Date:___________	☐ Permanent

☐ Non-Medical objection statement (Medical Provider signature not needed):

____
____
____

I acknowledge that un-vaccinated Children/Youth/Staff/Volunteer/Contractor may be excluded from attending CYS programs for prolonged periods during disease outbreak, without the ability to return until the outbreak ends.

Parent/Guardian/Staff Signature:	**Date:**	**Doctor Signature and Stamp:**	**Date:**

CYS Coordinator Signature:	**Date:**
Public Health Provider/Authority (Medical only):	**Date:**
Installation Command Signature (Non-Medical only):	**Date:**

For IMCOM Tracking ONLY:
Date Submitted to DCS, G-9: ___________
Date Submitted to TMT: _______________ TMT#_________________
Date Received back from TMT: _________

v: 11 Mar 21