CHILD, YOUTH, AND SCHOOL SERVICES HEALTH ASSESSMENT/SPORTS PHYSICAL (AE Reg 608-10-1)

Data required by the Privacy Act of 1974

Authority: 10 USC 3013.

Purpose: (1) Verify child health and status of immunizations for admission requirements; (2) Note special program considerations or restriction on child participation; (3) Execute emergency medical procedures for chronic illness or conditions; (4) Refer the child for enrollment in Exceptional Family Member Program; (5) Certify the child is physically fit to participate in sports.

Routine use: In addition to those disclosures generally permitted under 5 USC 552a(b) of the Privacy Act, these records and information may specifically be disclosed outside DOD as a routine use pursuant to 5 USC 552a(b)(3) as follows: Information from this system may be disclosed to civilian health and welfare departments and agencies in emergency situations. The "Blanket Routine Uses" set forth at the beginning of the Army Compilation of Systems of Records Notices also apply

Cell phone Sponsor unit/work address Spouse's work telephone Sponsor unit/work address Spouse's work telephone Sponsor unit/work address Spouse's work telephone Spouse Spouse's work telephone Spouse's work	Notices also apply. Disclosure: Voluntary, but if information	n is not provided, i	ndividuals	s ma	ay r	not be	e able to participate in C	hild, Youth, and S	School Services activities.				
Name of sponsor Home telephone Cell phone	Instructions: For health assessment	s, complete parts	A and C;	for	sp	orts	physicals, complete p	arts A, B, and C					
Cell phone Sponsor unit/work address Spouse's work telephone Sponsor unit/work address Sponsor		1	Part A					1					
Sponsor unit/work address Child Health Information Name of child Date of birth (YYYYMMDD) Sex Male Female				lephone				Work telephone					
Child Health Information Name of child Date of birth (YYYYMMDD) Sex Male Female													
Date of birth (YYYYMMDD) Sex Male Female	Sponsor unit/work address							Spouse's wo	ork telephone				
Date of birth (YYYYMMDD) Sex Male Female													
Does your child have ongoing medical concerns? (If yes, explain circumstances and current status.) No	Child Health Information Name of child				Da	ate of	f birth (YYYYMMDD)	Sex					
Does your child have ongoing medical concerns? (If yes, explain circumstances and current status.) No Yes Yes Yes Yes Yes No							,	Male	Fema	ale			
Syour child enrolled in the Exceptional Family Member Program? (If yes, explain.) No	Does your child have ongoing medic	cal concerns? (If y	es, explai	n ci	rcu	msta	nces and current status		į 🗀 -				
Medical History Yes No 1. ADD/ADHD 15. Head injury or loss of consciousness 16. Heart or blood pressure problems 17. Heat stroke or exhaustion 18. Joint injuries (ankle/knee/wrist) 19. Learning problems 10. Behavioral problems 10. Behavioral problems 10. Dental or orthodontic braces 11. Diabetes 12. Seech or development delays 12. Seech or development delays 13. Ear or hearing problems 14. Headaches 15. Head injury or loss of consciousness 16. Heart or blood pressure problems 17. Heat stroke or exhaustion 18. Joint injuries (ankle/knee/wrist) 19. Learning problems 20. Neck or back injury 21. Required restricted physical activity 22. Seizures or convulsions 23. Sleep problems 24. Speech or development delays 25. Vision problems (glasses/contacts) 26. Other (list below) 17. Head injury or loss of consciousness 18. Joint injuries (ankle/knee/wrist) 29. Chest pain with exercise 20. Neck or back injury 21. Required restricted physical activity 22. Seizures or convulsions 23. Sleep problems 24. Speech or development delays 25. Vision problems (glasses/contacts) 26. Other (list below) 27. Dizziness or fainting with exercise 28. Other (list below) 29. Chest pain with exercise 29. Chest pain with exercise 20. Other (list below) 20. Prequency 21. Prequency 22. Required restricted physical activity 23. Sleep problems 24. Speech or development delays 25. Vision problems (glasses/contacts) 26. Other (list below) 27. Prequency 28. Chest pain with exercise 29. Chest pain with exercise 20. Other (list below) 20. Prequency	No Yes												
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1. ADD/ADHD 15. Head injury or loss of consciousness 2. Allergies to medicine, insect bites, or food 16. Heart or blood pressure problems 2. Allergies to medicine, insect bites, or food 17. Heat stroke or exhaustion 2. Asthma or difficulty breathing 18. Joint injuries (ankle/knee/wrist) 2. Autism spectrum disorder 19. Learning problems 20. Neck or back injury 2. Autism spectrum disorder 20. Neck or back injury 21. Required restricted physical activity 22. Seizures or convulsions 23. Sleep problems 24. Speech or development delays 25. Vision problems 24. Speech or development delays 25. Vision problems 24. Speech or development delays 25. Vision problems 26. Other (list below) 27. Dizziness or fainting with exercise 27. Dizziness or fainting with exercise 28. Other (list below) 28. Ot	Medical History		! >	/ 05	!	No	1		!	V	20	! .	No
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3. Any hospitalization or operation 17. Heat stroke or exhaustion 4. Asthma or difficulty breathing 18. Joint injuries (ankle/knee/wrist) 5. Autism spectrum disorder 19. Learning problems 20. Neck or back injury 7. Broken bones or sprains 21. Required restricted physical activity 8. Cancer 22. Seizures or convulsions 9. Chest pain with exercise 23. Sleep problems 24. Speech or development delays 11. Diabetes 25. Vision problems (glasses/contacts) 12. Dizziness or fainting with exercise 26. Other (list below) 13. Ear or hearing problems 14. Headaches 15. Ongoing medications 15. Ongoing medications 16. Ongoing medicati	2. Allergies to medicine, insect bite	s, or food	<u> </u>		Ť	$\overline{\Box}$							╡
5. Autism spectrum disorder 6. Behavioral problems 7. Broken bones or sprains 9. Chest pain with exercise 10. Dental or orthodontic braces 11. Diabetes 12. Dizziness or fainting with exercise 13. Ear or hearing problems 14. Headaches 15. Outside the above, please explain: Ongoing medications Name Dosage 19. Learning problems 20. Neck or back injury 21. Required restricted physical activity 22. Seizures or convulsions 23. Sleep problems 24. Speech or development delays 25. Vision problems (glasses/contacts) 26. Other (list below) 27. Vision problems (glasses/contacts) 28. Vision problems (glasses/contacts) 29. Vision problems (glasses/contacts) 20. Vision problems (glasses/contacts) 21. Vision problems (glasses/contacts) 22. Vision problems (glasses/contacts) 23. Vision problems (glasses/contacts) 24. Speech or development delays 25. Vision problems (glasses/contacts) 26. Other (list below) 27. Vision problems (glasses/contacts) 28. Vision problems (glasses/contacts) 28. Vision problems (glasses/contacts) 29. Vision problems (glasses/contacts) 29. Vision problems (glasses/contacts) 29. Vision problems (glasses/contacts) 20. Vision problems (glasses/contact	-	<u> </u>			+	Ħ		e or exhaustion					Ħ
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9. Chest pain with exercise 10. Dental or orthodontic braces 11. Diabetes 12. Dizziness or fainting with exercise 12. Dizziness or fainting with exercise 13. Ear or hearing problems 14. Headaches 15 you answered yes to any of the above, please explain: 16 Ongoing medications Name 17 Dosage 18 Frequency Allergies - All types (food, medicines, insect bites)	7. Broken bones or sprains				-		21. Required restricte	ed physical activ	rity				
10. Dental or orthodontic braces	8. Cancer						22. Seizures or convu	ulsions					
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Ongoing medications Name Dosage Frequency Allergies - All types (food, medicines, insect bites)	13. Ear or hearing problems				1								
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Name Dosage Frequency Allergies - All types (food, medicines, insect bites)	If you answered yes to any of the ab	ove, please expla	in:										
Name Dosage Frequency Allergies - All types (food, medicines, insect bites)													
Allergies - All types (food, medicines, insect bites)	Ongoing medications												
	Name		Dosage	•			Fre	equency					
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Type Reaction							Type		Reaction				
	1,760						1,700						
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			Part B							
Age		aff Assessment (c Height	ompleted by lic	ensed indep		practition Weigh				
Yrs	Mos	licigit	% Ib/kg					%		
BP	1	Visual acuity (tes				9	<u>i</u>			
P		Right	,	. 3 ,		Left			/	
'		Normal	Abnorm	nal i N	I/A C	ommer	nts		•	
1. Eyes										
2. Ears, nose, and thro	at				+					
3. Hearing										
4. Mouth and teeth										
5. Neck (soft tissues)		 	!							
6. Cardiovascular		 		- 						
7. Chest and lungs		! ! !		-	+					
8. Abdomen		<u> </u> 	<u> </u>	- 	+					
9. Genitalia - hernia		 	!		+					
10. Skin and lymphatics		1	!							
11. Spine - scoliosis		 	1	-						
12. Extremities		! ! !								
13. Neurological		 								
14. Wears braces/plates			-							
Based on this examinati	on, the following abnorm	nalities were found	d and may nee	d treatmen	t:					
Immunizations are curre	ent and up to date	Yes	No							
Participation recommen	ded									
All sports	Yes No)		Normal p	hysical	l activit	y includir	ng physica	l education	ı
Additional comm			ons							
	Sports p	ohysical is valid		om date ir	ndicate	d belo	W.			
Part C Special medical considerations: Describe any special program needs, considerations, or restrictions that could affect the child's participation in Child, Youth, and School Services programs (including sports).										
	rticipate in normal Child,		ol Services pr	ograms:		es	No			
Licensed healthcare pro	fessional stamp	Date			Licens	sed hea	Ithcare pr	ofessiona	l signature	
Type or print name of pa	arent or guardian	Date			Signat	ure of	parent or	guardian		
		Health Assess	mont Annua	l Dogortifi	ection					
Health status changed		Date	ment Annua	Receitiii		ure of	parent or	guardian		
Yes No										
Health status changed		Date			Signat	ure of	parent or	guardian		
Yes No										