

**EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP)
CYS SERVICES PROGRAMS HEALTH/DEVELOPMENTAL SCREENING**

For use of this form, see AR 608-75; the proponent agency is ACSIM.

Installation: _____

MIAT Case Number: _____

PROOF

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 3013, Secretary of the Army; 29 U.S.C. 794, Nondiscrimination Under Federal Grants and Programs; DoDI 1342.17 Family Policy; AR 608-75, Exceptional Family Member Program; DoDI 6060.02, Child Development Programs; AR 608-10, Child Development Services.

PRINCIPAL PURPOSE: Information will be used to assist Army activities in their responsibilities in the overall execution of the Army's Exceptional Family Member Program and Child, Youth and School Services Programs.

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 utilize Army Child, Youth and School Services.

FOR PARENT CENTRAL SERVICES COMPLETION ONLY

<input type="checkbox"/> Initial Registration On waiting list? <input type="checkbox"/> Yes <input type="checkbox"/> No Date care needed? _____	<input type="checkbox"/> Re-registration <input type="checkbox"/> Change in Condition	Date in from Patron: _____ Date out to APHN: _____
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PART A - GENERAL INFORMATION (Parent completes)

Child/Youth Name	Child/Youth School Grade (example: 3rd Grade)	Date of Birth (YYYYMMDD)	Age
Type of Program Requested (check all that apply): <input type="checkbox"/> CDC <input type="checkbox"/> FCC <input type="checkbox"/> Hourly Care <input type="checkbox"/> Full Day Care <input type="checkbox"/> Middle School/Teen Program <input type="checkbox"/> Summer Camp <input type="checkbox"/> Other: _____ <input type="checkbox"/> Part Day Care <input type="checkbox"/> Before/After School Care <input type="checkbox"/> SKIESUnlimited <input type="checkbox"/> Sports and Fitness			
Sponsor Name/Rank	Sponsor Email	Sponsor SSN (Last 4 digits)	
Spouse Name	Spouse Email	Sponsor DOB	
Home Phone	Cell Phone	Sponsor Unit	
Home Address		Sponsor Duty Phone	

PART B - CHILD / YOUTH MEDICAL / DEVELOPMENTAL CONDITIONS (check yes or no)

Does your child/youth have:

1. Asthma/Reactive Airway Disease/Breathing Problems? <input type="checkbox"/> Yes <input type="checkbox"/> No a. Does it require a rescue medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	8. Emotional problems/difficulties? <input type="checkbox"/> Yes <input type="checkbox"/> No 9. Autism Spectrum Disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No a. Does it require a rescue medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	10. Developmental Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No 11. Visual problems/difficulties not corrected by glasses/contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Dietary Restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> a. Medically-based <input type="checkbox"/> b. Religiously-based	12. Hearing problems/difficulties? <input type="checkbox"/> Yes <input type="checkbox"/> No 13. Speech/language delays? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No	14. Other developmental delays? <input type="checkbox"/> Yes <input type="checkbox"/> No 15. Physical disability? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Epilepsy/Seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No	16. Other medical condition or concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____
6. Attention Deficit/Hyperactivity Disorder (ADD/ADHD)? <input type="checkbox"/> Yes <input type="checkbox"/> No a. Is your child/youth prescribed medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Diagnosed Behavior/Conduct concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No a. Is your child/youth prescribed medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	

PART C - MEDICATIONS

List any medications that are prescribed for your child/youth:

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

Child/Youth Name: _____

PART D - EARLY INTERVENTION AND SPECIAL EDUCATION

Does your child/youth receive special services/therapies? Yes No
If yes, please specify:

Does your child/youth have an:
a. Individualized Education Plan (IEP) Yes No
b. Individualized Family Service Plan (IFSP) Yes No
c. 504 Plan Yes No

PART E - EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) ENROLLMENT

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

If you have answered NO to all the questions above or YES to ONLY Part B, 3b., sign and date below, indicating that the information above is accurate and complete to the best of your knowledge.

Printed Name of Parent/Personal Representative of Child/Youth	Signature of Parent/Personal Representative of Child/Youth	Date (YYYYMMDD)
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If you answered YES to any of the questions above (OTHER THAN PART B, 3b.), complete Part F below.

Child, Youth and School Services (CYS 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 status please notify CYS Services immediately.

PART F - RELEASE OF INFORMATION

Is this child/youth currently covered by TRICARE or other military health care? Yes No

I authorize _____ to release any medical information regarding my child/youth
(name of Medical Treatment Facility or physician's practice)

_____ to the _____
(name of child) (name of installation)

CYS Services and Multidisciplinary Inclusion Action Team (MIAT) personnel, are necessary to conduct a MIAT 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 MIAT team 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 of Parent/Personal Representative of Child/Youth	Signature of Parent/Personal Representative of Child/Youth	Date (YYYYMMDD)
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