UNITED STATES ARMY
CHILD & YOUTH SERVICES

Army Child and Youth Services (CYS)
Program Registration and Consent Form

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, United States Code, Section 3012. **PRINCIPAL PURPOSE(S):** To provide Child and Family program eligibility, background information and sponsor consent for access to emergency medical care. ROUTINE USES: Information is furnished to the attending physician when it is necessary for an individual to be taken to a medical facility by someone other than the parent. **DISCLOSURE:** Disclosure of requested information is voluntary, however, if information is not provided, Individual(s) may not be allowed to participate in the CYS Program. **DECLARATION OF NONDISCRIMINATION:** Services will be made available to all youth in attendance, without regard to race, religion, national origin, ancestry, or sex, within the limits or IMCOM Regulation 608-10.

Sponsor's Name: _____ **Grade/Rank:** _____
Last First MI

Status: ☐ Active Duty ☐ Guard ☐ Reserve ☐ DoD Civilian ☐ Eligible Contractor ☐ Other

Branch of Service: ☐ Army ☐ Air Force ☐ Navy ☐ Marine Corps ☐ Coast Guard

Installation Assigned to: _____

Unit/Employer: _____ **Duty Phone:** _____

Unit/Employer Address: _____

Home Address: _____ **City:** _____

Home Phone: _____ **Cell Phone:** _____ **Live On-Post? ☐Yes ☐No**

Sponsor's Email Address (@mail.mil Preferred): _____

I want to receive email information and announcements about CYS Programs and Events:
☐ Yes ☐ No

Spouse's Name: _____ **Grade/Rank:** _____
Last First MI

Status: ☐ Active Duty ☐ Guard ☐ Reserve ☐ DoD Civilian ☐ Eligible Contractor

☐ Student ☐ Retired Military ☐ Other (Please Specify) _____

Branch of Service: ☐ Army ☐ Air Force ☐ Navy ☐ Marine Corps ☐ Coast Guard

Unit/Employer: _____ **Duty Phone:** _____

Unit/Employer Address: _____

Home Phone: _____ **Cell Phone:** _____

Spouse's Email Address (@mail.mil Preferred): _____

Child's Name: _____ **Nickname:** _____
Last First MI
Gender: **Male** **Female** **Date of Birth:** _____/_____/_____ **Age:** _____ **Grade:** _____
MM DD YYYY

Child's Name: _____ **Nickname:** _____
Last First MI
Gender: **Male** **Female** **Date of Birth:** _____/_____/_____ **Age:** _____ **Grade:** _____
MM DD YYYY

Child's Name: _____ **Nickname:** _____
Last First MI
Gender: **Male** **Female** **Date of Birth:** _____/_____/_____ **Age:** _____ **Grade:** _____
MM DD YYYY

Child's Name: _____ **Nickname:** _____
Last First MI
Gender: **Male** **Female** **Date of Birth:** _____/_____/_____ **Age:** _____ **Grade:** _____
MM DD YYYY

Child's Name: _____ **Nickname:** _____
Last First MI
Gender: **Male** **Female** **Date of Birth:** _____/_____/_____ **Age:** _____ **Grade:** _____
MM DD YYYY

<u>Emergency Contacts</u> (2 Local Adults, other than sponsor or spouse, authorized to respond in an emergency)

Name: _____ **Home Phone:** _____ **Cell Phone:** _____
Last First MI
Address: _____ **Relationship:** _____
***Is this person authorized to pick up child?** ☐ **Yes** ☐ **No**

Name: _____ **Home Phone:** _____ **Cell Phone:** _____
Last First MI
Address: _____ **Relationship:** _____
***Is this person authorized to pick up child?** ☐ **Yes** ☐ **No**

SPONSOR CONSENT

I,_____, Parent/Guardian of_____,(circle one) ***<u>give consent</u>*** / ***<u>do not give consent</u>*** for an authorized CYS representative to obtain medical and/or dental care for my child in an emergency situation where his/her condition represents a serious or imminent threat to his/her life, health, or wellbeing. I understand that a conscientious effort will be made to notify me prior to such action and the expense, if any, will be paid by me. Treatment at an Army Medical Facility may be provided without additional consent under the provision of AR 40-3.
Sponsor's Initials: _____

Does your child have permission to travel in a government/commercial vehicle to participate in CYS Programs and events? ☐ **Yes** ☐ **No**

Can your child be photographed while participating in a CYS Program for release to media? ☐ **Yes** ☐ **No**

SPONSOR'S SIGNATURE: _____ **DATE:** _____

Verifying Staff Member: _____ **Verification Date:** _____
Special Needs? ☐ **Yes** ☐ **No (If Yes) Date Received Health Screening Tool-1 from Sponsor**_____

Sole/Dual Military Family: As prescribed by AR 600-20 and AR 608-10, military personnel are required to maintain an accurate Family Care Plan. DA Form 5305-R must be completed within 30 days of CYS registration or services may be denied. The Family Care Plan must be updated annually.
Sponsor's Initials: _____

The following additional documentation is REQUIRED no later than 30 days from initial registration; failure to provide this information will result in denial of CYS Program participation:

----------For CYS Staff----------

☐ **Health Assessment** **Suspense Due Date** _____
☐ **Emergency Contacts** **Suspense Due Date** _____
☐ **Family Care Plan** **Suspense Due Date** _____