Reset Form

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: _____

SNAP Case Number: _____

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 POS COMPLETION ONLY

☐ Initial Registration
On waiting list? ☐ Yes ☐ No
Date care needed? _____

☐ Re-registration/already in program
☐ Current Program
☐ Change in Condition

Date in from Patron: _____

Date out to APHN: _____

PART A- GENERAL INFORMATION *(Parent completes)*

Child/Youth's Name	Child/Youth School Grade *(example: 3rd Grade)*	Date of Birth *(YYYYMMMDD)*	Age

Type of Program Requested *(check all that apply):*

☐ Hourly Care ☐ Full Day Care ☐ Middle School/Teen Program ☐ Summer Camp ☐ Other: _____
☐ Part Day Care ☐ Before/After School Care ☐ SKIES/Instructional Classes ☐ Sports

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

PART C - MEDICATIONS

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

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

Child/Youth's 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 *(YYYYMMMDD)*

If you answered YES to any of the questions above (OTHER THAN PART B, 3b.), complete Part F below.

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 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
(name of Medical Treatment Facility or physician's practice)

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

Child, Youth & School (CYS) services and Multidisciplinary Inclusion Action Team (MIAT) personnel, that 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 *(YYYYMMMDD)*

Child/Youth's Name: _____

PART G - ARMY PUBLIC HEALTH NURSE (APHN) CASE REVIEW

Medical Records Reviewed? ☐ Yes ☐ No ☐ Not Available

Special Needs/Diagnosis:

Medical History *(Applicable to Special Needs/Diagnosis)*:

Training Required for CYS Staff/FCC Provider *(detail type of training, who will provide the training and projected timeline)*:

Recommendation Summary *(if additional space is needed please add a continuation page)*:

REVIEWED *(check all that apply)*:

☐ Allergy MAP ☐ Diabetes MAP ☐ Epilepsy/Seizure MAP ☐ Respiratory MAP ☐ Special Diet Statement

MULTIDISCIPLINARY INCLUSION ACTION TEAM REQUIRED:

☐ **Administrative** ☐ **Modified** ☐ **Full** ☐ **Annual Review**

APHN Printed Name or Stamp	APHN Signature	Date *(YYYYMMDD)*

Date Received by APHN *(YYYYMMMDD)*	Date Returned to Parent Central Services/EFMP *(YYYYMMMDD)*