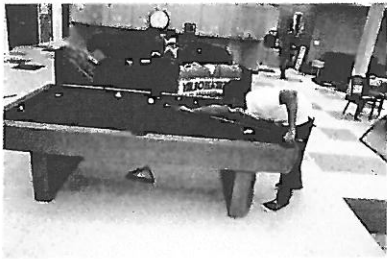




U.S. Army Child, Youth  
& School Services



# FORT SILL YOUTH CENTER



HOUR OF OPERATION

MON-THURS: 1400-2000

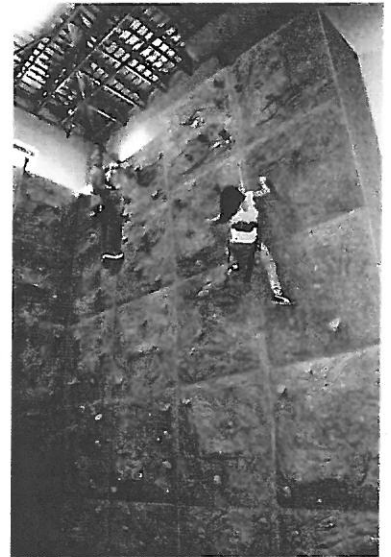
FRI-SAT: 1400-2200

CONTACT NUMBER:

442-6745

ADDRESS:

1010 FORT SILL BLVD.



JOIN US BY PARTICIPATING IN VARIOUS ACTIVITIES SUCH AS PASSPORT TO MANHOOD, SMART GIRLS, COOKING, FITNESS, ART AND TECHNOLOGY ACTIVITES. WE HAVE A STATE OF THE ART FACILITY THAT OFFERS SNACK, SEPARATE ACTIVITY SPACES, ROCK WALL, GYM, TECHNOLOGY LAB, LEARNING KITCHEN AND MUCH MORE.



LIKE US ON FACEBOOK.COM

-SILL CYSS TEEN-

\*CONTACT THE YOUTH CENTER FOR SUNDAY DATES.



BOYS & GIRLS CLUBS  
OF AMERICA

# CYSS Youth Program Registration & Sponsor Consent

*Middle and High School Teens: It's so easy to enjoy CYSS activities now! Just fill out this form (don't forget the back side), get your parent to sign it and then return it (scan, fax, email or deliver) to your local Youth Program (YP) or Parent Central Services (formerly known as CER). CYSS staff will verify your registration telephonically with your parent or guardian within 5 working days of receipt of form. Here's a look at some opportunities CYSS offers: dances, trips, classes, volunteer opportunities; homework assistance; up-to-date technology and internet access; place to meet friends; summer camps and more!*

### 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 of AR 608-10.

**YOUTH:** Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Nickname \_\_\_\_\_

Gender: (circle one) M / F Grade \_\_\_\_\_ School \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

E-mail Address: \_\_\_\_\_

I authorize YP to email me information and announcements about programs and events: Yes \_\_\_\_\_ No \_\_\_\_\_

**SPONSOR:** Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Status: Act Duty / Guard / Reserve / DOD Civ / Other \_\_\_\_\_ (If Mil: Rank \_\_\_\_\_ Branch: AR / AF / NA / MA / CG )

Unit/Employer \_\_\_\_\_ Unit/Emp Address \_\_\_\_\_ APO AE \_\_\_\_\_

Kaserne/Post \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mailing Address \_\_\_\_\_ APO AE \_\_\_\_\_

Home Phone \_\_\_\_\_ On-Post? Y or N Sponsor Email Address \_\_\_\_\_

**SPOUSE:** Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Status: Act Duty / Guard / Reserve / DOD Civ / Other Employed Civ / Student / Retired / Unemployed / Other \_\_\_\_\_

(If Mil: Rank \_\_\_\_\_ Branch: AR / AF / NA / MA / CG ) Spouse Email Address \_\_\_\_\_

Unit/Employer \_\_\_\_\_ Unit/Emp Address \_\_\_\_\_ City \_\_\_\_\_

Zip \_\_\_\_\_ Bldg #/Kaserne \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

### EMERGENCY/RELEASE CONTACTS (Local adults, not parents, authorized to respond in an emergency):

1. Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Work Ph \_\_\_\_\_ Cell \_\_\_\_\_

Home Phone \_\_\_\_\_ Is this person authorized to pick-up youth? Yes \_\_\_\_\_ No \_\_\_\_\_

2. Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Work Ph \_\_\_\_\_ Cell \_\_\_\_\_

Home Phone \_\_\_\_\_ Is this person authorized to pick-up youth? Yes \_\_\_\_\_ No \_\_\_\_\_

Please continue on back side

**SPONSOR CONSENT:** I, \_\_\_\_\_, parent/guardian of \_\_\_\_\_, give consent for an authorized CYSS representative to obtain medical/dental care for my youth in an emergency situation where his/her condition represents a serious or imminent threat to his/her life, health, or well being. 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.

Does your Youth have any special needs (asthma, allergies, ADHD, physical disabilities, dietary restrictions, etc.)  
Yes \_\_\_ No \_\_\_ (If yes, DA form 7625-1 will be sent to you for completion and must be returned within 5 days.)

Can your Youth be photographed while participating in a CYSS program for release to the media? Yes \_\_\_ No \_\_\_

Does your Youth have permission to access social networking sites? Yes \_\_\_ No \_\_\_

If yes, does your Youth have permission to access the internet? Yes \_\_\_ No \_\_\_

I have reviewed the information on this form and to the best of my knowledge, the information is accurate.

DATE: \_\_\_\_\_ Parent/Guardian SIGNATURE: \_\_\_\_\_

**STAFF TELEPHONIC VERIFICATION:** Name of verifying parent: \_\_\_\_\_

Staff Name \_\_\_\_\_ Verification Date \_\_\_\_\_ Time \_\_\_\_\_

Special needs? Y or N If yes, date DA 7625-1 sent to parent: \_\_\_\_\_ Date returned: \_\_\_\_\_

Date CYSS pass issued: \_\_\_\_\_ Staff Signature \_\_\_\_\_

We look forward to seeing you in our programs and encourage parents to drop by anytime to see the great things happening in our Youth Programs. If you would like more information, please call one of the numbers listed below:

#### **Youth Center (YC) Program Information:**

1010 Fort Sill Blvd., 580-442-6745 fax 580-442-5658

#### **Hours of Operation:**

Monday-Thursday 1400-2000, Friday & Saturday-1400-2200

The YC follows the LPS school calendar, opening at 1300 on days schools are closed. Camps are offered during LPS breaks (fall, winter & spring) 0700-1300.

Youth Center office opens at 1100 daily (M-F) for parent convenience. (Doors may open later due to trainings, meetings, etc.)

Guardian/Sponsor may have to come in to the Youth Center to sign other required forms.

The YC is closed all Federal Holidays and some Training Holidays (signs will be posted).

Parent Central Services (PCS) Information: 442-3486/3927/4836 PCS Office Hours 0730-1630 M-F.

#### **Notes:**

1. Youth may attend the regular Youth Programs (no field trips or special events until registration is finalized) as a guest member immediately upon receipt of completed form.
2. CYSS staff will validate form registration. If registration is not validated within 5 working days from receipt of form, youth's guest membership will be cancelled.
3. Once registration is validated (and, if required, DA 7625-1 is completed and returned), annual pass will be issued to youth.
4. Some special events and field trips may cost a nominal fee, but participation in these events is not mandatory. In the case of field trips, written parental permission must be granted before a youth is allowed to participate.
5. To enroll in a team sports program, a sports physical is required in addition to this registration. Sports fees may also apply.

# 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.

**FOR CER COMPLETION ONLY:**

Initial Registration  
 Is child on waiting list? \_\_\_\_\_  
 Re-registration/Child Already in Care  
 Change in Program

## Part A – General Information

Child's Name	Child's School Grade (example: Third Grade)	Date of birth (YYYYMMDD)
Type of Placement Requested: (check all that apply)		
<input type="checkbox"/> Hourly Care	<input type="checkbox"/> Full Day Care	<input type="checkbox"/> Middle School/Teen Program
<input type="checkbox"/> Part Day Care	<input type="checkbox"/> Before/After School Care	<input type="checkbox"/> Summer Camp
	<input type="checkbox"/> SKIES/Instructional Classes	<input type="checkbox"/> Sports
Sponsor Name		Sponsor E-mail
Sponsor SSN		
Spouse Name		Spouse E-mail
Home Phone	Cell Phone	Alternate Phone

## Part B – Identification of Child/Youth Condition/Restrictions

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

<p>1. Allergies</p> <p>a. Life threatening reaction? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>b. Epi-pen prescribed? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>c. Does child need rescue inhaler <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If your child has an allergy please list: _____</p>	<p>7. Does your child have diabetes? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>8. Does your child require a special diet? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>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 Please specify: _____</p>
<p>2. Asthma/Reactive Airway Disease/Breathing Problems? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>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). Explain: _____</p> <p>If your child has a minor speech/language or hearing issues are they on an IEP, IFSP or 504 Plan? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>
<p>3. Attention Deficit Disorder (ADD/ADHD)</p> <p>a. ADD/ADHD NOT well controlled with medication? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>b. Are there behavior/conduct concerns? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>c. List ADD/ADHD medications: _____</p>	<p>11. Does your child have developmental delays other than MILD speech language/MILD hearing loss? Please explain: _____</p>
<p>4. Behavior/conduct concerns (oppositional defiant disorders/anxiety disorders, depression, bipolarity)? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	
<p>5. Autism Spectrum Disorders (Autism, Asbergers, Rett Syndrome, PDD-NOS) <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	
<p>6. Does your child have seizures? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	

## Part C - Medications

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

## Part D – Early Intervention and Special Education

Does your child receive special services/therapies  No  Yes

Does your child 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: \_\_\_\_\_

**If you have answered NO to all the questions above you are now finished with this form.  
Please sign and date below.**

\_\_\_\_\_  
Signature of Parent/Personal Representative of Child

\_\_\_\_\_  
Date (YYYYMMDD)

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

Child's Name	Date of Birth (YYYYMMDD)
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**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. In understand I may revoke this consent in writing at any time before expiration, but any action taken by the SYC/SNAP in reliance on this authorization prior to revocation is valid and will remain in effect.

I understand that information disclosed pursuant to this authorization if 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.

\_\_\_\_\_  
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:

Background/Notes: (Diagnosis: \_\_\_\_\_)

Recommendations: (Training, special care requirements)

Is full SNAP team meeting required?  No  Yes

Requirements Prior to Placement:

Action plan \_\_\_\_\_  
(type)

APHN Signature:	Date of Review:
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Youth Name \_\_\_\_\_ Age \_\_\_\_\_ Sponsor Name \_\_\_\_\_

**I, the parent/guardian of the youth named above, grant permission of him/her to participate in the Youth Center activities as follows:**

\_\_\_\_\_ to all on-post and off-post excursions. I assume all risks and hazard incidentals to such participation including transportation to and from the activities. I absolve, and agree to hold the Fort Sill installation and all its agents acting officially, harmless of any claim arising out of damage to any property or from an injury to my youth other than a claim resulting from negligence.

\_\_\_\_\_ to participate in swimming activities. Each trip will require an additional permission slip signed by you.

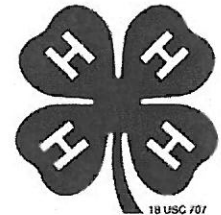
\_\_\_\_\_ to participate in 4-H activities. These include activities designed to promote leadership and to foster volunteerism. To build partnerships that strengthens families and communities. Youth additional information will be used for reporting purposes.



School \_\_\_\_\_ Grade \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_

Phone \_\_\_\_\_ Ethnicity \_\_\_\_\_ (not required)

Mailing Address \_\_\_\_\_



**Permission Slip for 11 & 12 Year Olds at the Fort Sill Youth Center**

Middle School and Teen years offer new and exciting opportunities for independence and mastery skills. In order to provide parents with accurate information on the location of their children, we are now requiring parents of kids that are 11 & 12 years old to sign this form.

**I do allow my youth to leave the Fort Sill Youth Center** – Allows your youth to leave the Youth Center without permission from you without supervision from the Fort Sill Youth Center Staff. (walk to the commissary, PX, post office, Burger King, bowling alley)

**I do NOT allow my youth to leave the Fort Sill Youth Center** – Means that the youth will be advised **NOT** to leave without permission. But in the event that he/she still chooses to leave the Fort Sill Youth Center, a parent will be contacted immediately. \*Permission is granted upon a member of the Youth Center staff actually speaking with the parent/guardian on the phone.

Please list a phone number where you can be easily reached.

First # \_\_\_\_\_ Alternate # \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**6<sup>th</sup> Grade Parents:**

**Yes – I want a phone call if my 6<sup>th</sup> grader does not check in with the Youth Center staff after school.**

**No – I do not want a phone call if my 6<sup>th</sup> grader does not check in with the Youth Center staff after school.**

\*Please notify the Youth Center at 442-6745 if your 6<sup>th</sup> grader will not be attending the Youth Center that day.

CHILD, YOUTH & SCHOOL SERVICES  
MFLC Consent form

I acknowledge that a CYB-MFLC is available and authorize my child, \_\_\_\_\_, to receive CYB-MFLC support.

\_\_\_\_\_  
PARENT OR GUARDIAN SIGNATURE

I acknowledge that a CYB-MFLC is available and **DO NOT** authorize my child, \_\_\_\_\_, to receive CYB-MFLC support.

\_\_\_\_\_  
PARENT OR GUARDIAN SIGNATURE