ARMY CHILD AND YOUTH SERVICES HEALTH SCREENING TOOL

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

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.

Part A - General Information

1. Child's Name	2. Date of birth (YYYYMMDD)
3. Family member prefix	
4. Type of placement requested	5. Date (YYYYMMDD)
6. Sponsor name	7. SSN (last four digits)
8. Spouse name	

9. Home phone	10. Duty phone	11. Cell phone

Part B - Identification of Child/Youth Condition/Restrictions

Child has any of the following conditions/restrictions: (Check yes or no)

1. Allergies
   ☐ No ☐ Yes (explain)

   a. Life threatening reaction
   ☐ No ☐ Yes (explain)

   b. Epi-pen required
   ☐ No ☐ Yes

   c. Other allergic reations (hives, rash, diarrhea)
   ☐ No ☐ Yes

2. Asthma reactive airway disease
   ☐ No ☐ Yes (explain)

   a. Triggers exist for child's asthma attacks (stress, environmental, exercise)
   ☐ No ☐ Yes (explain)

   b. Child routinely (greater than 10 days per month/four months per year) uses inhaled anti-inflammatory agents and/or bronchodilators
   ☐ No ☐ Yes (explain)

   c. Child has taken steroids during the past year (prednisone, prednisolone)
   ☐ No ☐ Yes (indicate number of days in past year)

d. Child has experienced unconsciousness or seizures associated with asthma attacks

☐ No ☐ Yes (explain)

e. Child required an urgent visit to emergency room or clinic for acute asthma within the last 12 months

☐ No ☐ Yes (indicate number of visits in the past year)

f. Child has been hospitalized for asthma related condition in the past six months

☐ No ☐ Yes (explain)

3. Attention Deficit Disorder (ADD)

☐ No ☐ Yes

a. ADD with hyperactivity

☐ No ☐ Yes

b. Is not well controlled with medication

☐ No ☐ Yes (not well controlled)

c. Behavioral/conduct concerns

☐ No ☐ Yes (explain)

4. Autism

☐ No ☐ Yes

5. Behavioral/conduct concerns (for example, oppositional defiant disorder, anxiety disorder, school phobias)

☐ No ☐ Yes (explain)

6. Blindness/visual problems

☐ No ☐ Yes (explain)

7. Diabetes

☐ No ☐ Yes (explain)

8. Emotional problems that require care by a psychiatrist, psychologist or social worker

☐ No ☐ Yes (explain)

9. Epilepsy

☐ No ☐ Yes (explain)

10. Hearing problems

☐ No ☐ Yes (explain)

11. Heart problems

☐ No ☐ Yes (explain)

12. Kidney problems

☐ No ☐ Yes (explain)

13. Speech/language delay

☐ No ☐ Yes (explain)

14. Physical disability

☐ No ☐ Yes (explain)

15. Dietary restrictions

☐ No ☐ Yes (explain)

16. Assistance with activities of daily living

☐ No ☐ Yes (explain)

17. Other conditions

☐ No ☐ Yes (specify and explain)

Part C - Medications

Child is on medications on a regular basis

☐ No ☐ Yes (If yes, please list medications and indicate which require administration during child care hours.)

Part D - Early Intervention and Special Education

Child has an Individualized Family Service Plan (IFSP), Individualized Education Plan (IEP) or 504 plan

☐ No ☐ Yes

Part E - Exceptional Family Member Program (EFMP) Enrollment

Child is enrolled in the EFMP

☐ No ☐ Yes (specify for what condition)

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. I understand I may revoke this consent in writing at any time before expiration, but any action taken by the CYS/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 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.

_____ Signature of Parent or Personal Representative of Child

_____ Date (YYYYMMDD)