U.S. Marine Corps Children, Youth & Teen Programs (CYTP) Health Assessment

Privacy Act Statement:

AUTHORITY: 10 U.S.C. § 5013; 10 U.S.C. § 5041; and Marine Corps Order P1710.30E. **PRINCIPAL PURPOSE:** This System of Records is governed by Privacy Act System of Records Notice NM01754-3 which can be downloaded at http://dpclo.defense.gov/privacy/SORNs/component/navy/NM01754-3.html. Information provided is used by USMC personnel to: (1) verify child required immunizations per admission requirements; (2)be used by the Inclusion Action Team to determine necessary and appropriate accommodations in CYTP activities.; (3) execute emergency medical procedure for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program; and (5) determine if at time of enrollment child is physically fit to participate in USMC CYTP programs. **ROUTINE USES:** In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, to various officials outside the Department of Defense (DoD) specifically identified in Privacy Act System of Records notice NM01754-3, and pursuant to the blanket routine uses established by DoD that apply to all DoD Privacy Act Systems of Records and posted at http://privacy.defense.gov/blanket_uses.shtml. **DISCLOSURE:** Information is voluntary; however, if information is not provided, individuals may not be able to participate in CYTP activities.

SPONSOR INFORMATION (please print)

Name of Sponsor		Sponsor Unit
Home Phone	Cell Phone	Duty/Work Phone

CHILD/YOUTH INFORMATION (please print)

Name of Child/Youth	Birth Date	☐ Male ☐ Female	Enrolled in Public School ☐ Yes ☐ No

CHILD'S/YOUTH'S MEDICAL HISTORY (Check all that apply)

1. Any hospitalization or operations		14. Heat stroke or exhaustion	
2. Allergies to medicine, insect bites, latex or food (please explain reactions)		15. Broken bones or sprains	
3. Development delays/Learning problems		16. Joint injuries	
4. Eye or vision Problems (Glasses/Contacts)		17. Restricted physical activity	
5. Ear or hearing problems		18. Diabetes	
6. Seizures or Convulsions		19. Cancer	
7. Dizziness or fainting with exercise		20. Dental	
8. Headaches		21. Mental Health Issues	
9. Head injury or loss of consciousness		22. Sleep problems	
10. Neck or back injury		23. Behavioral problems	
11. Asthma or difficulty breathing		24. ADD/ADHD	
12. Heart or blood pressure problems		25. Benign skin colorations (e.g., birthmarks)	
13. Chest pain with exercise		26. Other problems	

If any apply, please explain

Is the child/youth enrolled in Exceptional Family Member Program? (Specify what branch of Service) ☐ Yes ☐ No	Has your child been seen by a Health Care provider regarding their Special Need within the last year? ☐ Yes ☐ No
Does the child/youth have any special needs/considerations (including religious/cultural)? ☐ Yes ☐ No * If there are special considerations, a Health Screening Tool for Inclusion Action Team will need to be completed by the healthcare provider.	Does the child/youth have ongoing medical concerns? (If Yes, explain circumstances and current status) ☐ Yes ☐ No

PHYSICAL EXAMINATION (To be completed by Health Care Provider)(May attach last physical if within last 12 months)

Height:	Weight:	BP:	HR:

	Normal	Abnormal	N/A		Normal	Abnormal	N/A
1. Eyes				8. Chest/Abdomen			
2. ENT				9. Genitalia			
3. Hearing				10. Skin			
4. Mouth/Teeth				11. Lymphatic			
5. Neck				12. Spine			
6. Cardiovascular				13. Extremities			
7. Respiratory				14. Neurological			

Based on this examination, the following abnormalities were found and may need treatment

Immunizations are current and up to date ☐ Yes ☐ No (if no, please explain) *A copy of the child/youth immunization must be given to CYTP

Child/Youth is able to participate in normal CYTP programs? ☐ Yes ☐ No (if no, please explain)

Date	Parent/Guardian Signature	Health Care Provider Stamp or Printed Name & Address
Date	Health Care Provider Signature	

U.S. Marine Corps Children, Youth & Teen Programs (CYTP) Health Assessment
Health Screening Tool for Inclusion Action Team (IAT)

REQUIRED ONLY IF THE CHILD/YOUTH HAS SPECIAL NEEDS/CONSIDERATIONS. TO BE COMPLETED BY PARENT AND HEALTH CARE PROVIDER OR APPROPRIATE SPECIALIST

Identification of Child/Youth Special Need(s) (use provided space to elaborate on the special need)

What special need(s) does the child/youth have?

Asthma/Reactive Airway Disease ☐ Allergies (other than seasonal/allergic rhinitis) ☐ Behavioral ☐ Neurological ☐
Developmental (e.g. Autism/PDD/Delays) ☐ Other (explain) ☐

Brief summary of the child's/youth's needs

Medication

Child is on medications related to special needs? ☐ No ☐ Yes (list medications below and indicate which require administration during child care hours)

For medically diagnosed allergies, is Epinephrine required? ☐ Yes ☐ No

For other diagnoses, are any emergency medications required (e.g. Glucagon, Diastat, Albuterol)? ☐ Yes ☐ No

CURRENT MEDICATIONS INCLUDING EMERGENCY (If more space needed, please attach additional documents)

Name	Dosage	Frequency	During Child Care
			☐
			☐
			☐

Assistance with activities of daily living? ☐ No ☐ Yes (explain)

Dietary modifications? ☐ No ☐ Yes (explain)

Environmental adaptations (e.g. room temperature, wheelchair access)? ☐ No ☐ Yes (explain)

Other conditions/adaptations/modifications/recommendations/concerns or comments to ensure the child's/youth's needs are met? (specify and explain) ☐ No ☐ Yes

Carry and Self-Administer Authorization (to be completed by health care provider)

☐ N/A

☐ YES — I have instructed this youth in the proper way to use his/her medication. It is my professional opinion that he/she SHOULD be allowed to carry and self administer his/her medication. This youth has been instructed not to share medications.

☐ NO — It is my professional opinion that this child/youth SHOULD NOT carry or self administer his/her medication.

For youth who self-administer and carry their own medication(s), the medication MUST accompany the youth at all times. The options of storing "back up" rescue medications at the program is available. The youth must not share medications. Should the youth violate these restrictions the privilege of self medicating will be revoked and the youth parents notified. Youth are required to notify staff when carrying medication upon check in at CYTP activity. *Rescue medications MUST accompany children/youth during any off-site activities.

Health Care Provider or Specialist Signature	Date	Health Care Provider Stamp or Printed Name & Address
Phone	Email	

Early Intervention and Special Education

Child has an Individualized Family Service Plan (IFSP), Individualized Education Plan (IEP), 504 plan or Behavioral Plan? ☐ No ☐ Yes

If yes, does he/she have an aide, skills trainer, or additional assistance? ☐ No ☐ Yes

For Special Ed/Early Intervention, is the child currently seeing a therapist? ☐ No ☐ Yes

I understand that all reasonable efforts will be made to accommodate all properly documented special needs based on IAT determinations. Parent/guardian(s) will be notified if care accommodations cannot be honored and invited to attend subsequent meetings. I acknowledge that CYTP is not responsible for providing the child/youth with services that would be considered skilled nursing or behavioral, occupational, or physical therapy.
I understand that this form must be updated annually, or earlier, if there is a change in condition or need.

Parent/Guardian Signature	Date

Office Use Only-Reviewed by CYTP Nurse or Other Designated Personnel

Signature	Date	IAT Meeting date if required