



CHILD AND YOUTH SERVICES (CYS) REGISTRATION

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; 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 Child and Youth 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 and Youth Services.

FOR STAFF COMPLETION

☐ Initial Registration On waiting list? ☐ YES ☐ NO ☐ Re-registration/already in program ☐ Information Update

Date care needed:

Date received from patron:

FOR PARENT COMPLETION

Type of Program Requested (Check all that apply)

☐ Hourly Care ☐ Full Day Care ☐ Part Day Care ☐ Before/After School Care ☐ Summer Camp ☐ Middle School/Teen
☐ SKIES/Instructional Classes ☐ Youth Sports & Fitness ☐ Universal PreK ☐ Other:

Child/Youth's Name

School Grade

Date of Birth (YYYY/MM/DD)

Age

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Sponsor Name

Rank

Sponsor Email (official email, when applicable)

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Sponsor Unit/Employer

Sponsor Cell Phone

Sponsor Duty Phone

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Spouse Name

Spouse Email

<input type="text"/>	<input type="text"/>
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Spouse Unit/Employer

Spouse Cell Phone

Spouse Duty Phone

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Home Address

<input type="text"/>

Emergency Contact 1

Emergency Contact 2

Last Name, First Name:

Phone:

Authorized to pick up child/youth?

☐ YES

☐ NO

Last Name, First Name:

Phone:

Authorized to pick up child/youth?

☐ YES

☐ NO

Does your child receive special services / therapies?

☐ YES

☐ NO

Does your child have seizures?

☐ YES

☐ NO

If yes to either of the above, please specify:

I certify that the information above is accurate and complete to the best of my knowledge.

Printed Name of Parent/Personal Representative

Signature (CAC Digital Signature)

Date (YYYY/MM/DD)

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Click to sign with CAC / digital certificate