USAG Wiesbaden
CYS Registration Checklist
Birth to 5th Grade

Parent Central Services
Heining Street, Building # 1213
DSN: 548-9356
CIV: 0611-143-548-9356

Hours of Operation:
Mo, Tu, We, and Fr: 0800-1600
Thursday: 1300-1800
E-mail: usarmy.wiesbaden.id-europe.list.mwr-central-registration@mail.mil

Mandatory Documentation / Information Needed for CYS Registration:

- CYS Demographic Form
- Sponsor's Social Security Number
- Orders / Command Sponsorship / U.S. Military ID card
- Family Care Plan, DA Form 5305-R, for Dual/Single Military Families
  Due within 30 days of placement
- LES / Pay Stub / Student verification, for Sponsor & Spouse (for placements only)
  Copies of the income verification must be within the last 90 days, in order to verify income category fees for childcare. When proper documentation is not provided, the household fees will be assessed at the highest fee category level.
- CYS Health Assessment / Sports Physical (AE Form 608-10-1A)
  Due within 30 days of registration
- Up to date Immunization Record (Infant – Kindergarten only)
- CYS Health Screening Tool (DA Form 7725)
  If any questions answered with "yes", please see below:

  Additional paperwork is required and will have to be completed by your child's physician. Please contact our Parent Central Services Office for more information
  - Respiratory Medical Action Plan: Asthma, Reactive Airway Disease
  - Allergy Medical Action Plan: Food Allergy or Intolerance
  - Special Diet Statement: Food Allergies
  - Seizure Action Plan: Seizure Disorders
  - Diabetes Medical Action Plan: Diabetes
- Medication Listed on any Medication Action Plans
  Parents must bring any medication(s) and prescription label(s) that are required to be administered while child(ren) are participating in CYS programs. The medication must be in the original container with a childproof cap. Prescription label(s) on the medication bottle/box must be in English. If not, the medication translation form must be completed, signed, stamped and dated by a physician. All prescription labels must include the date of issue, child's first and last name, physician's name, name of the medication, dosage, method of administration and instructions for use.

Children must be fully registered before they can use any CYS programs.

For more information, please, contact Parent Central Services.

UNITED STATES ARMY
CHILD & YOUTH SERVICES

USAG Wiesbaden Demographic Sheet

SPONSOR:

Last Name________________________________First Name: _________________________

Status: Act Duty_____Guard________Reserve_______DOD CIV_______Non-DOD Fed Emp. _______

Contractor_____Other_____________

If Mil: Rank___________Branch: AR_______AF______NA_____MA_____CG_____

Sponsor SSN#__________________ DEROS/PCS Date________

Housing Location: On Post_____Off Post______

If on post, please check a Housing area:

Hainerberg_____Aukamm_____Crestview_____Clay Kaserne_____Newman_______

CMR___________________Box___________________________APO- AE______________________________________

Home Phone:_______________________________Cell Phone: _______________________________

Sponsor Work Email:______________________________________Sponsor Email: __________________________

Unit / Employer____________________________________Work Phone: __________________________________

UNITED STATES ARMY
CHILD & YOUTH SERVICES

SPOUSE:

Last Name________________________________First Name: _________________________

Status: Act Duty_____Guard________Reserve_______DOD CIV_______Non-DOD Fed Emp. _______

Contractor_____Student___________Retired_______Unemployed_______Other _______

If Mil: Rank___________Branch: AR_______AF______NA_____MA_____CG_____

Home Phone:_______________________________Cell Phone: _______________________________

Spouse Work Email:______________________________________Spouse Email: ____________________________

Unit / Employer____________________________________Work Phone: ______________________________________

USAG Wiesbaden Demographic Sheet

CHILDREN'S INFORMATION

1.

Last Name:_____________________First Name:_____________________Special Needs: Yes______No________

Gender: Male_____Female_____Grade________DOB___________________Age______Ethnicity____________

2.

Last Name:_____________________First Name:_____________________Special Needs: Yes______No________

Gender: Male_____Female_____Grade________DOB___________________Age______Ethnicity____________

3.

Last Name:_____________________First Name:_____________________Special Needs: Yes______No________

Gender: Male_____Female_____Grade________DOB___________________Age______Ethnicity____________

4.

Last Name:_____________________First Name:_____________________Special Needs: Yes______No________

Gender: Male_____Female_____Grade________DOB___________________Age______Ethnicity____________

5.

Last Name:_____________________First Name:_____________________Special Needs: Yes______No________

Gender: Male_____Female_____Grade________DOB___________________Age______Ethnicity ____________

EMERGENCY / RELEASE CONTACTS (other than parents, must have access to post, radius of 1 hour drive)

1. Last Name__________________First Name ___________________

   Work Phone_________________Cell_________________________Home Phone _____________________

   Is this Person authorized to pick up? Yes______No _______

2. Last Name__________________First Name ___________________

   Work Phone_________________Cell_________________________Home Phone _____________________

   Is this Person authorized to pick up? Yes______No _______

3. Last Name__________________First Name ___________________

   Work Phone_________________Cell_________________________Home Phone _____________________

   Is this Person authorized to pick up? Yes______No _______

UNITED STATES ARMY
CHILD & YOUTH SERVICES

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: ____________________

PROOF

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? ☐ Yes ☐ No
    If yes, please explain:

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, 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)*

Print Form | E-mail Form | Reset Form | Prescribing Directive

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CHILD, YOUTH, AND SCHOOL SERVICES HEALTH ASSESSMENT/SPORTS PHYSICAL
(AE Reg 608-10-1)

Data required by the Privacy Act of 1974

Authority: 10 USC 3013.

Purpose: (1) Verify child health and status of immunizations for admission requirements; (2) Note special program considerations or restriction on child participation; (3) Execute emergency medical procedures for chronic illness or conditions; (4) Refer the child for enrollment in Exceptional Family Member Program; (5) Certify the child is physically fit to participate in sports.

Routine use: In addition to those disclosures generally permitted under 5 USC 552a(b) of the Privacy Act, these records and information may specifically be disclosed outside DOD as a routine use pursuant to 5 USC 552a(b)(3) as follows: Information from this system may be disclosed to civilian health and welfare departments and agencies in emergency situations. The "Blanket Routine Uses" set forth at the beginning of the Army Compilation of Systems of Records Notices also apply.

Disclosure: Voluntary, but if information is not provided, individuals may not be able to participate in Child, Youth, and School Services activities.

Instructions: For health assessments, complete parts A and C; for sports physicals, complete parts A, B, and C.

Part A

Name of sponsor	Home telephone	Work telephone
	Cell phone	
Sponsor unit/work address		Spouse's work telephone

Child Health Information

Name of child	Date of birth (YYYYMMDD)	Sex
		☐ Male ☐ Female

Does your child have ongoing medical concerns? (If yes, explain circumstances and current status.)

☐ No ☐ Yes

Is your child enrolled in the Exceptional Family Member Program? (If yes, explain.)

☐ No ☐ Yes

Medical History

	Yes	No		Yes	No
1. ADD/ADHD	☐	☐	15. Head injury or loss of consciousness	☐	☐
2. Allergies to medicine, insect bites, or food	☐	☐	16. Heart or blood pressure problems	☐	☐
3. Any hospitalization or operation	☐	☐	17. Heat stroke or exhaustion	☐	☐
4. Asthma or difficulty breathing	☐	☐	18. Joint injuries (ankle/knee/wrist)	☐	☐
5. Autism spectrum disorder	☐	☐	19. Learning problems	☐	☐
6. Behavioral problems	☐	☐	20. Neck or back injury	☐	☐
7. Broken bones or sprains	☐	☐	21. Required restricted physical activity	☐	☐
8. Cancer	☐	☐	22. Seizures or convulsions	☐	☐
9. Chest pain with exercise	☐	☐	23. Sleep problems	☐	☐
10. Dental or orthodontic braces	☐	☐	24. Speech or development delays	☐	☐
11. Diabetes	☐	☐	25. Vision problems (glasses/contacts)	☐	☐
12. Dizziness or fainting with exercise	☐	☐	26. Other (list below)	☐	☐
13. Ear or hearing problems	☐	☐			
14. Headaches	☐	☐			

If you answered *yes* to any of the above, please explain:

Ongoing medications

Name	Dosage	Frequency

Allergies - All types (food, medicines, insect bites)

Type	Reaction	Type	Reaction

Print Form | E-mail Form | Reset Form

Go to page 1

Part B

Medical Staff Assessment (completed by licensed independent practitioner)

Age		**Height**		**Weight**	
Yrs	**Mos**	**in/cm**	**%**	**lb/kg**	**%**
BP /		**Visual acuity** (tested with/without glasses)			
P		**Right** /		**Left** /	

	Normal	Abnormal	N/A	Comments
1. Eyes				
2. Ears, nose, and throat				
3. Hearing				
4. Mouth and teeth				
5. Neck (soft tissues)				
6. Cardiovascular				
7. Chest and lungs				
8. Abdomen				
9. Genitalia - hernia				
10. Skin and lymphatics				
11. Spine - scoliosis				
12. Extremities				
13. Neurological				
14. Wears braces/plates				

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

Immunizations are current and up to date ☐ Yes ☐ No

Participation recommended

☐ All sports ☐ Yes ☐ No

☐ Normal physical activity including physical education

☐ Additional comments

☐ Restrictions

Sports physical is valid for 1 year from date indicated below.

Part C

Special medical considerations: Describe any special program needs, considerations, or restrictions that could affect the child's participation in Child, Youth, and School Services programs (including sports).

Child/youth is able to participate in normal Child, Youth, and School Services programs: ☐ Yes ☐ No

Licensed healthcare professional stamp	**Date**	**Licensed healthcare professional signature**
Type or print name of parent or guardian	**Date**	**Signature of parent or guardian**

Health Assessment Annual Recertification

Health status changed	**Date**	**Signature of parent or guardian**
☐ Yes ☐ No		
Health status changed	**Date**	**Signature of parent or guardian**
☐ Yes ☐ No		

"This document conforms to the privacy act of 1974:10 USC 3013."

PASS SALES RECEIPT

Receipt #
Payment Date:

Parent Central Services
Unit 29623 Box 0051
Child &Youth Services
APO AE 09096-0051
Phone: 548-9356
Visit us on the Web at: https://webtrac.mwr.army.mil

Hm Ph:
Wk Ph:

Pass Details

Fees + Tax	Discount	Prev Paid	Cur Paid	Amount Due
0.00	0.00	0.00	0.00	0.00

Pass Holder: **YS Privilege (CY-MZZ)**
Pass
Valid
Pass

Re-Registration is an annual requirement. Registration must be current in order to participate in any CYS Programs and Activities.

Families that fail to show proof of their TFI, or fail to provide a signed copy of the new TFI before previous document expiration, will be charged Category 9 child care fees. If the required documents are provided at a later date, the TFI Category is adjusted accordingly and new fees are effective from the date the documents are received.

CURRENT Sports physicals are a requirement for sports participation.

SKIES payments are due on the 1st of every month. Participation is contingent upon payment. Lack of payment may result in withdrawal from services.

A written two week withdrawal notice is required prior to dropping an activity. Withdrawal forms or notices must be turned in to the Parent Central Services. Instructors will not accept withdrawal notices.

Payment must be received at time of enrollment for all Sports, and Skies programs. Hourly care can not be scheduled or attended until an hourly orientation has been completed. I have read and understand these requirements of the CYS programs.

Parent Name ___________________________

Parent Signature ___________________________ Date ________________

Processed on by

FEES CHARGED ON NEW LINE ITEMS (+)	0.00
DISCOUNT APPLIED AGAINST THESE FEES (-)	0.00
TAX CHARGED ON NEW FEES (+)	0.00
NEW AMOUNT DUE	**0.00**
PREVIOUS NET HOUSEHOLD BALANCE	0.00
TOTAL DUE	**0.00**
NEW FEES PAID ON THIS RECEIPT (-)	0.00
TOTAL PAID	**0.00**
NEW NET HOUSEHOLD BALANCE	0.00

DEPARTMENT OF THE ARMY
UNITED STATES ARMY GARRISON - WIESBADEN
UNIT 29623
APO AE 09096

REPLY TO
ATTENTION OF

IMWB-MWC

MEMORANDUM FOR RECORD

SUBJECT: Statement of Understanding, Hourly Care Usage

Reference: CYS Services Fee Policy 2019/2020 ANNEX B and ANNEX E, Standing Operating Procedures (SOP) for CYS Hourly/Respite Care Reservations

1. Hourly care must be paid in full on the day service is provided. Patrons with outstanding hourly care payments, late pick-up fees, and/or no show fees will not be allowed to use or reserve a space for hourly care until fees are paid in full.

2. Patrons are requested to cancel hourly reservations by 0800 on the day the care is to be provided. Patrons must contact the facility they have reservations with to cancel. CYS will charge patrons for “No Shows” and late cancellations. The fee is $10.00 per reservation per child for all patrons.

3. I, ___________________________________ (Full Name of Parent/Guardian), understand:

a. If I have an outstanding hourly care balance on my CYS account, I will not be allowed to reserve a space for hourly care until all outstanding fees are paid in full.

b. If I have standing hourly reservations with an outstanding balance due on my account, those standing reservations will not be honored until payment has been made. Hourly care will be denied until all outstanding fees have been paid.

In the event I do not honor the reservation I have made, I will be charged a “No Show” fee of $10.00 per missed reservation or late cancellation per child.

____

Patron Signature Date

____

CYS Staff Name / Signature Date

DEPARTMENT OF THE ARMY
UNITED STATES ARMY GARRISON - WIESBADEN
UNIT 29623
APO AE 09096

REPLY TO
ATTENTION OF

IMWB-MWR-C 13 December 2019

Statement of Understanding for Families of Children and Youth with Special Needs

Special needs are defined as any conditions and/or restrictions listed on the Army CYS Health/Developmental Screening (DA Form 7725), the CYS Health Assessment and Sports Physical (AE Form 608-10-1A).

I, ____, understand that after I bring in the required forms signed by the physician to Parent Central Services my child(ren)'s special need(s) must be cleared by the Wiesbaden Army Health Clinic Public Health Nurse before registration can be completed.

The special needs clearance process can takes up to 16 working days. Some conditions and/or restrictions may require a Multidisciplinary Inclusion Action Team (MIAT) meeting, which will add additional time to the clearance process. This process is required to enable our staff and program to better meet your child(ren)'s needs.

New Registration

___ I understand that my child(ren) have to wait for completion of the special needs clearance process in order to participate in any CYS programs or activities.

If my child is already participating in CYS programs:
Re-registration

___ I understand that I have to start the re-registration process at least 30 days before my child(ren)'s pass expires.

___ I understand that the expired approved Medical Action Plan(s) and medication(s) in the program cannot be used during an emergency and until the new Medical Action Plan(s) and medication(s) are approved by the Public Health Nurse my child will not be able to attend the program/activity.

Already in the Program, New Condition

___ I understand that CYS staff cannot administer the new rescue medication to my child(ren) until the new Medical Action Plan(s) and medication(s) are approved by the Public Health Nurse. In case of an emergency, the CYS staff will call an ambulance.

Medication Prescription label

___ I understand that on the first day of attendance my child/youth medication prescription label has to be presented to the front office of the program my child/youth is attending.

____

Parent Name (Please Print) Parent Signature and Date

____

Staff Name Staff Signature and Date

DEPARTMENT OF THE ARMY
UNITED STATES ARMY GARRISON - WIESBADEN
UNIT 29623
APO AE 09096

REPLY TO
ATTENTION OF

IMWB-MWR-C 13 December 2020

MEMORANDUM FOR: Parents with children who require medication while attending Child and Youth Services

In accordance with the Army Regulation titled,' Operations Manual' if your child requires medication while attending Child and Youth Services programs, the medication must be in the original container with a childproof cap. Each medication container must be labeled with the date of issue, child's first name and last name, the Health Care Provider's name, name of the medication, dosage, method of administration, and instructions for use.

All prescriptions must be in English or have a translation provided by the prescribing Host Nation Health Care Provider. The information must match the child's Medical Action Plan and Heath Assessment/Sports physical.

If your child receives medical services from a Host Nation Health Care Provider, please take this memo and ask the bottom portion to be completed for each medication your child needs.

For routine medications with a stop date such as antibiotics, please ensure your child has taken the medication 24 hours before the program can administer it to your child.

If you have questions, please contact the Child and Youth Services Health Nurse, Whitney Schindewolf, at DSN 548-9358, CIV 0611-143-548-9358.

Whitney Schindewolf, RN. BSN, MBA
CYS Health Nurse

Date of Issue: ____________

1. Child's first and last name: ______________________________
2. Name of Medication: ______________________________
   (Must match the original medication container or package and Medical Action Plan)
3. Dosage of Medication: ______________________________
4. Method of Administration: ______________________________
5. Instructions for use: ______________________________

****May administer second dose of Epinephrine after (15 or less) ____ minutes if symptoms worsen or do not resolve**

<u>Please note- CYS now requires 2 Epi-pens/Epi-pen Jr/ Fastjekt/Fastjekt Jr</u>**

6. Physician's Full Name, telephone number and stamp: ______________________________