

NAVY CHILD AND YOUTH PROGRAMS REGISTRATION FORM

START DATE: _____

REQUIRING DIRECTIVE OPNAVINST 1700.9

NAME OF CHILD (LAST, FIRST, MIDDLE)		SEX	BIRTHDATE (DD/MM/YY)		AGE
SPONSORS NAME (LAST, FIRST, MIDDLE)		SOCIAL SECURITY NUMBER	RANK/RATE	BRANCH	STATUS: ACT RET RES CIV CTR COMCIV
HOME ADDRESS (Include City and Zip Code)				HOME PHONE	
E-MAIL ADDRESS				CELL PHONE	
DUTY STATION			DUTY PHONE		DATE OF ROTATION
(CIRCLE ONE) SINGLE PARENT FULL-TIME WORKING SPOUSE PART-TIME WORKING SPOUSE		DUAL MILITARY STUDENT SPOUSE UNEMPLOYED SPOUSE		IF SPOUSE IS MILITARY (PLEASE CIRCLE) STATUS: ACT RET ENL OFF	
SPOUSE'S NAME (LAST, FIRST)		PLACE OF EMPLOYMENT	PHONE NUMBER	CELL PHONE	

EMERGENCY NOTIFICATION/RELEASE DESIGNEE (other than parents) (minimum of TWO (2) LOCAL REQUIRED)

NAME	PHONE NUMBER	RELATIONSHIP

PROGRAM ENROLLED: CDC CDH BEFORE SCHOOL AFTER SCHOOL VACATION CAMP TEENS
 YOUTH SPORTS OPEN REC KINDERGARTEN CARE INSTRUCTIONAL CLASSES

SCHOOL NAME: _____ GRADE: _____

DATE OF LAST MEDICAL EXAM: _____ STATUS GOOD HEALTH IF NOT, PLEASE SPECIFY: _____

ALLERGIES: YES NO

IF YES, WHAT? _____

SPECIAL NEEDS: YES NO

IF YES, EXPLAIN: _____

HAS YOUR CHILD'S CASE BEEN REVIEWED BY THE SPECIAL NEEDS REVIEW BOARD: YES NO

DOES YOUR CHILD HAVE AN EXCEPTIONAL FAMILY MEMBER CLASSIFICATION: YES NO

IF YES, WHAT IS THE CLASSIFICATION: _____

SPONSOR AGREEMENT:

I HEREBY GIVE MY CONSENT FOR AN AUTHORIZED CHILD AND YOUTH PROGRAM (CYP) REPRESENTATIVE TO CALL AN AMBULANCE FOR MY CHILD, _____, ONLY FOR CARE (MEDICAL OR DENTAL) IN AN EMERGENCY SITUATION. I UNDERSTAND THAT A CONSCIENTIOUS EFFORT WILL BE MADE TO NOTIFY ME OR MY EMERGENCY DESIGNEES PRIOR TO SUCH ACTION. ANY EXPENSE INCURRED WILL BE BORNE BY ME AND TREATMENT MAY TAKE PLACE AT ANY MEDICAL FACILITY.

NAME OF CHILD'S MEDICAL INSURANCE COMPANY: _____

POLICY NUMBER: _____ NAME OF INSURED: _____

SPONSOR SIGNATURE _____ DATE _____ CYP REPRESENTATIVE SIGNATURE _____ DATE _____

PRIVACY ACT STATEMENT:

AUTHORITY: P.L. 101-89, Sec. 1507, "Military Child Care Act of 1989"; Title 5 U.S.C. 301 Department Regulations; E.O. 9397; and OPNAVINST 1700.9 "Child and Youth Programs."

PURPOSE: To provide Child and Youth Programs (CYP) with authorization for medical treatment in emergency situations; identify children and sponsors; record required immunizations; and record known allergies and special instructions.

ROUTINE USES: Information may be furnished to military or civilian doctors or hospitals in the course of obtaining medical attention for children. The SSN is necessary so that the Child and Youth Programs can identify the individual and his/her records. Information furnished may be disclosed to any DoD component, and upon request, to other federal, state and local governmental agencies in the pursuit of their official duties relating to proper child care. Finally, the information may be disclosed to law enforcement activities for the purpose of litigation.

VOLUNTARY DISCLOSURE: Furnishing the information is voluntary; however, failure to provide the requested information could result in denial of a child's admission to the CYP.

