

CHILD AND YOUTH SERVICES (CYS) REGISTRATION

and SPONSOR CONSENT FORM

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, United States Code, Section 3012. **PRINCIPAL PURPOSE(S):** To provide child and family program eligibility and background information; sponsor consent for access to emergency medical care; data required by USDA food program. **ROUTINE USES:** Information is furnished to the attending physician when it is necessary for a child to be taken to a medical facility by someone other than the parent. Information on immunization and medical problems will be used as part of the program admission screening procedure. Family income data will be used to determine USDA food program qualification and rate structure. **DISCLOSURE:** Disclosure of requested information is voluntary; however, if information is not provided, individuals may not be allowed to participate in CYS programs.

DECLARATION OF NONDISCRIMINATION

Services will be made available to all children in attendance, without regard to race, color, religion, national origin, ancestry, or sex, within the limits of AR 608-10. CYS programs participating in the USDA Food Program shall offer meals without physical segregation of or discrimination against any child regardless of ability to pay.

Personal data is solicited under Executive Order 9397 and the Authority of Title 10, USC, Section 1012. Other information will be used to determine eligibility for participation in the Fort Benning Child and Youth Services Program.

SPONSOR

SSN _____ Rank _____ Branch _____

 First Name Last Name Work Phone Cell Phone Home Phone

 Home Street Address City, State & Zip Unit City, State, Zip

If Fort Benning, please circle appropriate housing area: Indianhead Custer Patton McGraw Bouton/Davis Upatoi MainPost BattlePark

SPOUSE

Rank _____ Branch _____ (If Dual Military)

 First Name Last Name Work Phone Cell Phone Home Phone

 Employer / Unit Name City, State & Zip Retired / Reserve / Guard / DOD / Private Sector / Student
 (Circle One)

CHILDREN

NOTE: Please obtain code for Ethnicity, School, and Member Status from reverse side of form.

_____ First Name	_____ Last Name	_____ DOB (MM/DD/YY)	_____ SSN	Male / Female MbrStatus _____	Ethnicity ____ Age _____	School ____ Grade _____
_____ First Name	_____ Last Name	_____ DOB (MM/DD/YY)	_____ SSN	Male / Female MbrStatus _____	Ethnicity ____ Age _____	School ____ Grade _____
_____ First Name	_____ Last Name	_____ DOB (MM/DD/YY)	_____ SSN	Male / Female MbrStatus _____	Ethnicity ____ Age _____	School ____ Grade _____
_____ First Name	_____ Last Name	_____ DOB (MM/DD/YY)	_____ SSN	Male / Female MbrStatus _____	Ethnicity ____ Age _____	School ____ Grade _____

EMERGENCY / RELEASE CONTACT INFORMATION (local person other than parents)

 First Name Last Name Work Phone Cell Phone

 City State Zip Home Phone

Service Member's AKO E-mail Address: _____

SPONSOR CONSENT: I, _____, parent/guardian of _____ give consent for an authorized CYS representative to take my child for care (medical or dental) in an emergency situation where the child's condition represents a serious or imminent threat to his/her life, health, or well being. I understand that a conscientious effort will be made to notify me prior to such action and the expense, if any, will be paid by me. Treatment at an Army medical facility may be provided without additional consent under the provision of AR 40-3.

I have reviewed the information on this form and to the best of my knowledge, the information is accurate.

DATE _____ (Month/Day/Year) SIGNATURE _____

SOLE AND DUAL MILITARY: As prescribed by AR 600-20 and AR 608-10, military personnel are required to maintain an accurate Family Care Plan. DA Form 5305 must be completed within 30 days of CYS registration or services may be denied. The Family Care Plan must be updated annually or more frequently to maintain current information. _____ (Initial)

To Be Completed by CYS Staff	Child's Name	Parent's Initials	
Registration _____ to _____	_____	_____	Cards Issued _____
Renewal _____ to _____	_____	_____	Cards Issued _____
Renewal _____ to _____	_____	_____	Cards Issued _____
Renewal _____ to _____	_____	_____	Cards Issued _____

I understand I will be charged a \$5 replacement fee for each card after the initial two cards per child have been received.

- 1-White Caucasian / White
- 2-Black African American / Black
- 3-Native American Indian / Alaska Native
- 4-Cuban Cuban
- 4-Mexica Mexican / Mexican American / Chicano
- 4-Puerto Rican Puerto Rican
- 4-XOther Other Spanish / Hispanic / Latino
- 5-Asian Asian Indian
- 5-Chines Chinese
- 5-Filipi Filipino
- 5-Japan Japanese
- 5-Korean Korean
- 5-Vietna Vietnamese
- 5-XOther Other Asian
- 6-Guam Guamanian / Chamario
- 6-Hawaii Native Hawaiian
- 6-Somoan Somoan
- 6-XOther Other Pacific Islander
- 7-XOther Other (Not Listed Above)
- 9-ZDec Declined to State

MEMBER STATUS (MbrStatus)

Relationship to Sponsor

- S Son
- D Daughter
- SS Stepson
- SD Stepdaughter
- FS Foster Son
- FD Foster Daughter
- GD Granddaughter
- GS Grandson
- NC Niece
- NW Nephew

SCHOOL

- S Stowers
- D Dexter
- L Loyd
- M McBride
- W White
- WI Wilson
- F Faith Middle School
- OP Off Post School
- HS Home School

- Copy Military/DOD/Contract ID Card _____
- Verify & Annotate DEERS/Mil ID/Tricare _____
- Child's Social Security Number _____
- Local Emergency POC Completed _____
- SNAP Reviewed / Faxed / Copied _____
- Immunizations Entered (Birth - PreK Age & HSs) _____
- Sponsor's Consent Completed / Signed _____
- Suspense Form Completed / Signed _____
- Pass Dates Changed in CYMS to Suspense Date and Notes Entered (Child / SAS / MST Only) _____

Program other than Hourly Care or Sports

- Copy LES / Pay Stub _____
- Income Entered in CYMS _____
- Orientation Form Completed/Signed _____
- Orientation Packet Prepared _____
(Health Assessment, Fee Assessment, FCP)
- FCC Packet _____
(Health Assessment, Fee Assessment, FCP, CYMS Print Out)

Items Required for Re-Registration

- Parent & POC Info Updated _____
- Immunizations Updated _____
- Age / Grade / School Updated _____
- Fees Reassessed & Entered in CYMS _____
- Health Assessment Resigned _____
- Suspense Form Completed / Signed _____
- Pass Dates Changed in CYMS to Suspense Date and Notes Entered (Child / SAS / MST Only) _____
- Packet Prepared for Center _____
(Health Assessment, Fee Assessment, FCP)

