

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
		<input type="checkbox"/> Male <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	15. Head injury or loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>
2. Allergies to medicine, insect bites, or food	<input type="checkbox"/>	<input type="checkbox"/>	16. Heart or blood pressure problems	<input type="checkbox"/>	<input type="checkbox"/>
3. Any hospitalization or operation	<input type="checkbox"/>	<input type="checkbox"/>	17. Heat stroke or exhaustion	<input type="checkbox"/>	<input type="checkbox"/>
4. Asthma or difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	18. Joint injuries (ankle/knee/wrist)	<input type="checkbox"/>	<input type="checkbox"/>
5. Autism spectrum disorder	<input type="checkbox"/>	<input type="checkbox"/>	19. Learning problems	<input type="checkbox"/>	<input type="checkbox"/>
6. Behavioral problems	<input type="checkbox"/>	<input type="checkbox"/>	20. Neck or back injury	<input type="checkbox"/>	<input type="checkbox"/>
7. Broken bones or sprains	<input type="checkbox"/>	<input type="checkbox"/>	21. Required restricted physical activity	<input type="checkbox"/>	<input type="checkbox"/>
8. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	22. Seizures or convulsions	<input type="checkbox"/>	<input type="checkbox"/>
9. Chest pain with exercise	<input type="checkbox"/>	<input type="checkbox"/>	23. Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>
10. Dental or orthodontic braces	<input type="checkbox"/>	<input type="checkbox"/>	24. Speech or development delays	<input type="checkbox"/>	<input type="checkbox"/>
11. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	25. Vision problems (glasses/contacts)	<input type="checkbox"/>	<input type="checkbox"/>
12. Dizziness or fainting with exercise	<input type="checkbox"/>	<input type="checkbox"/>	26. Other (list below)	<input type="checkbox"/>	<input type="checkbox"/>
13. Ear or hearing problems	<input type="checkbox"/>	<input type="checkbox"/>			
14. Headaches	<input type="checkbox"/>	<input type="checkbox"/>			

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

Ongoing medications	Dosage	Frequency
Name		

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

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

<input type="checkbox"/> All sports	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Normal physical activity including physical education
<input type="checkbox"/> Additional comments	<input type="checkbox"/> 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
<input type="checkbox"/> Yes <input type="checkbox"/> No		

Health status changed	Date	Signature of parent or guardian
<input type="checkbox"/> Yes <input type="checkbox"/> No		