U.S. Marine Corps Children, Youth & Teen Programs (CYTP) Health Assessment

Privacy Act Statement:

AUTHORITY: 10 U.S.C. § 5013; 10 U.S.C. § 5041; and Marine Corps Order P1710.30E. **PRINCIPAL PURPOSE:** This System of Records is governed by Privacy Act System of Records Notice NM01754-3 which can be downloaded at http://dpclo.defense.gov/privacy/SORNs/component/navy/NM01754-3.html. Information provided is used by USMC personnel to: (1) verify child required immunizations per admission requirements; (2)be used by the Inclusion Action Team to determine necessary and appropriate accommodations in CYTP activities.; (3) execute emergency medical procedure for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program; and (5) determine if at time of enrollment child is physically fit to participate in USMC CYTP programs. **ROUTINE USES:** In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, to various officials outside the Department of Defense (DoD) specifically identified in Privacy Act System of Records notice NM01754-3, and pursuant to the blanket routine uses established by DoD that apply to all DoD Privacy Act Systems of Records and posted at http://privacy.defense.gov/blanket_uses.shtml. **DISCLOSURE:** Information is voluntary; however, if information is not provided, individuals may not be able to participate in CYTP activities.

SPONSOR INFORMATION (please print)

Name of Sponsor	Sponsor Unit

Home Phone	Cell Phone	Duty/Work Phone

CHILD/YOUTH INFORMATION (please print)

Name of Child/Youth	Birth Date	☐ Male ☐ Female	Enrolled in Public School ☐ Yes ☐ No

CHILD'S/YOUTH'S MEDICAL HISTORY (Check all that apply)

1. Any hospitalization or operations		14. Heat stroke or exhaustion	
2. Allergies to medicine, insect bites, latex or food (please explain reactions)		15. Broken bones or sprains	
3. Development delays/Learning problems		16. Joint injuries	
4. Eye or vision Problems (Glasses/Contacts)		17. Restricted physical activity	
5. Ear or hearing problems		18. Diabetes	
6. Seizures or Convulsions		19. Cancer	
7. Dizziness or fainting with exercise		20. Dental	
8. Headaches		21. Mental Health Issues	
9. Head injury or loss of consciousness		22. Sleep problems	
10. Neck or back injury		23. Behavioral problems	
11. Asthma or difficulty breathing		24. ADD/ADHD	
12. Heart or blood pressure problems		25. Benign skin colorations (e.g., birthmarks)	
13. Chest pain with exercise		26. Other problems	

If any apply, please explain

Is the child/youth enrolled in Exceptional Family Member Program? (Specify what branch of Service) ☐ Yes ☐ No _____	Has your child been seen by a Health Care provider regarding their Special Need within the last year? ☐ Yes ☐ No
Does the child/youth have any special needs/considerations (including religious/cultural)? ☐ Yes ☐ No * If there are special considerations, a Health Screening Tool for Inclusion Action Team will need to be completed by the healthcare provider.	Does the child/youth have ongoing medical concerns? (If Yes, explain circumstances and current status) ☐ Yes ☐ No _____

PHYSICAL EXAMINATION (To be completed by Health Care Provider)(May attach last physical if within last 12 months)

Height:	Weight:	BP:	HR:

	Normal	Abnormal	N/A		Normal	Abnormal	N/A
1. Eyes				8. Chest/Abdomen			
2. ENT				9. Genitalia			
3. Hearing				10. Skin			
4. Mouth/Teeth				11. Lymphatic			
5. Neck				12. Spine			
6. Cardiovascular				13. Extremities			
7. Respiratory				14. Neurological			

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

Immunizations are current and up to date ☐ Yes ☐ No (if no, please explain) *A copy of the child/youth immunization must be given to CYTP.

Child/Youth is able to participate in normal CYTP programs? ☐ Yes ☐ No (if no, please explain) _____

Date	Parent/Guardian Signature	**Health Care Provider Stamp or Printed Name & Address**
Date	Health Care Provider Signature	

U.S. Marine Corps Children, Youth & Teen Programs (CYTP) Health Assessment
Health Screening Tool for Inclusion Action Team (IAT)

REQUIRED ONLY IF THE CHILD/YOUTH HAS SPECIAL NEEDS/CONSIDERATIONS. TO BE COMPLETED BY PARENT AND HEALTH CARE PROVIDER OR APPROPRIATE SPECIALIST

Identification of Child/Youth Special Need(s) (use provided space to elaborate on the special need)

What special need(s) does the child/youth have?

Asthma/Reactive Airway Disease ☐ Allergies (other than seasonal/allergic rhinitis) ☐ Behavioral ☐ Neurological ☐
Developmental (e.g. Autism/PDD/Delays) ☐ Other (explain) ☐

Brief summary of the child's/youth's needs

Medication

Child is on medications related to special needs? ☐ No ☐ Yes (list medications below and indicate which require administration during child care hours)

For medically diagnosed allergies, is Epinephrine required? ☐ Yes ☐ No

For other diagnoses, are any emergency medications required (e.g. Glucagon, Diastat, Albuterol)? ☐ Yes ☐ No

CURRENT MEDICATIONS INCLUDING EMERGENCY (If more space needed, please attach additional documents)

Name	Dosage	Frequency	During Child Care
			☐
			☐
			☐

Assistance with activities of daily living? ☐ No ☐ Yes (explain)

Dietary modifications? ☐ No ☐ Yes (explain)

Environmental adaptations (e.g. room temperature, wheelchair access)? ☐ No ☐ Yes (explain)

Other conditions/adaptations/modifications/recommendations/concerns or comments to ensure the child's/youth's needs are met? (specify and explain) ☐ No ☐ Yes

☐ N/A Carry and Self-Administer Authorization (to be completed by health care provider)

☐ **YES** I have instructed this youth in the proper way to use his/her medication. It is my professional opinion that he/she SHOULD be allowed to carry and self administer his/her medication. This youth has been instructed not to share medications.

☐ **NO** It is my professional opinion that this child/youth SHOULD NOT carry or self administer his/her medication.

For youth who self-administer and carry their own medication(s), the medication MUST accompany the youth at all times. The options of storing "back up" rescue medications at the program is available. The youth must not share medications. Should the youth violate these restrictions the privilege of self medicating will be revoked and the youth parents notified. Youth are required to notify staff when carrying medication upon check in at CYTP activity.
*Rescue medications MUST accompany children/youth during any off-site activities.

Health Care Provider or Specialist Signature	Date	**Health Care Provider Stamp or Printed Name & Address**
Phone	Email	

Early Intervention and Special Education

Child has an Individualized Family Service Plan (IFSP), Individualized Education Plan (IEP), 504 plan or Behavioral Plan? ☐ No ☐ Yes

If yes, does he/she have an aide, skills trainer, or additional assistance? ☐ No ☐ Yes

For Special Ed/Early Intervention, is the child currently seeing a therapist? ☐ No ☐ Yes

I understand that all reasonable efforts will be made to accommodate all properly documented special needs based on IAT determinations. Parent/guardian(s) will be notified if care accommodations cannot be honored and invited to attend subsequent meetings. I acknowledge that CYTP is not responsible for providing the child/youth with services that would be considered skilled nursing or behavioral, occupational, or physical therapy.
I understand that this form must be updated annually, or earlier, if there is a change in condition or need.

Parent/Guardian Signature	Date

Office Use Only-Reviewed by CYTP Nurse or Other Designated Personnel

Signature	Date	IAT Meeting date if required

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

1. School/Agency Name	2. Site Name	3. Site Telephone Number
4. Name of Participant		5. Age or Date of Birth
6. Name of Parent or Guardian		7. Telephone Number

8. Check One:

☐ Participant has a disability or a medical condition and *requires* a special meal or accommodation. (Refer to definitions on reverse side of this form.) Schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. **A licensed physician must sign this form.**

☐ Participant does not have a disability, but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are encouraged to accommodate reasonable requests. **A licensed physician, physician's assistant, or nurse practitioner must sign this form.**

9. Disability or medical condition requiring a special meal or accommodation:

10. If participant has a disability, provide a brief description of participant's major life activity affected by the disability:

11. Diet prescription and/or accommodation: (*please describe in detail to ensure proper implementation-use extra pages as needed*)

12. Indicate texture:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

13. Foods to be omitted and substitutions: (*please list specific foods to be omitted and suggested substitutions. you may attach a sheet with additional information as needed*)

A. Foods To Be Omitted	B. Suggested Substitutions

14. Adaptive Equipment:

15. Signature of Preparer*	16. Printed Name	17. Telephone Number	18. Date
19. Signature of Medical Authority*	20. Printed Name	21. Telephone Number	22. Date

*** Physician's signature is required for participants with a disability. For participants without a disability, a licensed physician, physician's assistant, or nurse practitioner must sign the form.**

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.

MEDICAL STATEMENT TO REQUEST SPECIAL MEALS AND/OR ACCOMMODATIONS

INSTRUCTIONS

1. **School/Agency:** Print the name of the school or agency that is providing the form to the parent.
2. **Site:** Print the name of the site where meals will be served (e.g., school site, child care center, community center, etc.)
3. **Site Telephone Number:** Print the telephone number of site where meal will be served. See #2.
4. **Name of Participant:** Print the name of the child or adult participant to whom the information pertains.
5. **Age of Participant:** Print the age of the participant. For infants, please use Date of Birth.
6. **Name of Parent or Guardian:** Print the name of the person requesting the participant's medical statement.
7. **Telephone Number:** Print the telephone number of parent or guardian.
8. **Check One:** Check (✓) a box to indicate whether participant has a disability or does not have a disability.
9. **Disability or Medical Condition Requiring a Special Meal or Accommodation:** Describe the medical condition that requires a special meal or accommodation (e.g., juvenile diabetes, allergy to peanuts, etc.)
10. **If Participant has a Disability, Provide a Brief Description of Participant's Major Life Activity Affected by the Disability:** Describe how physical or medical condition affects disability. For example: "Allergy to peanuts causes a life-threatening reaction."
11. **Diet Prescription and/or Accommodation:** Describe a specific diet or accommodation that has been prescribed by a physician, or describe diet modification requested for a non-disabling condition. For example: "All foods must be either in liquid or pureed form. Participant cannot consume any solid foods."
12. **Indicate Texture:** Check (✓) a box to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular".
13. **A. Foods to Be Omitted:** List specific foods that must be omitted. For example, "exclude fluid milk."
    B. Suggested Substitutions: List specific foods to include in the diet. For example, "calcium fortified juice."
14. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining. (Examples may include a sippy cup, a large handled spoon, wheel-chair accessible furniture, etc.)
15. **Signature of Preparer:** Signature of person completing form.
16. **Printed Name:** Print name of person completing form.
17. **Telephone Number:** Telephone number of person completing form.
18. **Date:** Date preparer signed form.
19. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
20. **Printed Name:** Print name of medical authority.
21. **Telephone Number:** Telephone number of medical authority.
22. **Date:** Date medical authority signed form.

DEFINITIONS*:

"A Person with a Disability" is defined as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

"Physical or mental impairment" means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

"Major life activities" include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

"Has a record of such an impairment" is defined as having a history of, or have been classified (or misclassified) as having a mental or physical impairment that substantially limits one or more major life activities.

(*Citations from Section 504 of the Rehabilitation Act of 1973 and Americans with Disabilities Act of 1990)

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