

# Tobyhanna Child, Youth & School Services

## Supplemental Sports/Health Assessment Form

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, United States Code, Section 3013  
 PRINCIPAL PURPOSE: Information is used by DA personnel to (1) verify child health and immunization status per admission requirements; (2) note special program considerations or restrictions on child participation; (3) execute emergency medical procedures for chronic illness/conditions  
 ROUTINE USES: Information provided may be released IAW the Army's blanket routine uses contained in AR 340-21.  
 DISCLOSURE: Disclosure of requested information is voluntary; however, if information is not provided individuals may not be able to participate in CYSS programs.

Child's Name (Last)	(First)	Parent/Guardian
Date of Birth	Address	Home Phone

***Part I-To be completed by the parent or guardian***

	YES	NO		YES	NO
Is your child enrolled in Exceptional Family Member Program (EFMP)			Is your child under regular supervision of a physician?		
Asthma			Surgery/Hospitalization		
Bedwetting			Restricted Physical Activity		
Broken Bones/Joint Problems			Rheumatic Fever		
Fainting Spells			Scoliosis		
Family History of Death before 50 years of age			Skin Problems		
Headaches			Sleep Problems		

Other(s), Please Specify:

Explanation(s) of "YES" answers:

I give permission for the release of information on this form for confidential use in meeting my child's health and educational needs in the Child, Youth & School Services programs.

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_

***Part II-Health Evaluation***

***(To be completed and signed by a licensed health care provider)***

Allergies to food, medication or insect stings (describe, if any):  NONE

Describe health problems or special needs requiring program accommodation or special care:  NONE

I request this child receive the following medication(s) from the Child, Youth & School Services staff.

Medication	Dose	Frequency	Route	Rx Duration

This child may participate in the following Tobyhanna CYSS instructional & sports programs ***(check ALL that apply):***

- CONTACT/COLLISION (field hockey, football, ice hockey, lacrosse, martial arts, soccer wrestling)
- LIMITED CONTACT/IMPACT (basketball, cheerleading, gymnastics, skating (ice, inline, roller) skiing, softball, volleyball)
- STRENUOUS NONCONTACT (dance, crew, running/track, swimming, tennis, weightlifting)
- MODERATELY STRENUOUS NONCONTACT (badminton, table tennis)
- NONSTRENUOUS NONCONTACT (archery, golf)
- NOT CLEARED AND RECOMMENDATIONS: \_\_\_\_\_

The above named child has been given a routine medical examination and has been found free of infectious or contagious disease and is capable of participating in the Child, Youth & School Services programs with the exceptions listed above.

PRINTED/TYPED NAME OF PHYSICIAN OR CRNP	NAME OF PHYSICIAN OR CRNP MEDICAL GROUP/HOSPITAL
SIGNATURE OF PHYSICIAN OR CRNP	ADDRESS
DATE	PHONE NUMBER