NAVY CHILD AND YOUTH PROGRAM
HEALTH INFORMATION FORM 1700/52

Child's Name (Last, First, Middle):	Sex:	Birthdate (MM/DD/YYYY):	Age:
Sponsor's Name (Last, First, Middle):			

SPONSOR ACKNOWLEDGEMENTS, PERMISSIONS, AND RELEASES

PART A: IDENTIFICATION OF CHILD/YOUTH MEDICAL AND/OR DIETARY NEEDS

(Some of these questions may require additional documentation. Please refer to the instructions on Page 2.)

1. Does your child have any medical needs that require assistance while in care? Yes ☐ No ☐
   If "Yes," please check all that apply below:

☐Asthma ☐Diabetes ☐Kidney Problems
☐Seizures ☐Heart Problems ☐Other Chronic Medical Needs (Describe below in #2.)
☐Physical Disability (Describe below in #2.) ☐Epilepsy

2. If you checked "Other Chronic Medical Needs" or "Physical Disability" in #1 above, please briefly describe your child's chronic medical needs or physical disability:

3. Does your child suffer from other allergies or allergic reactions (e.g., seasonal hay fever, bee stings, hives, rashes, etc.)? ☐ Yes ☐ No
   If "Yes," please list the allergies/allergic reactions:

4. Does your child have any food allergies? ☐Yes ☐ No If "Yes," please list all food allergies and reaction to each food your child experiences:

5. Does your child require an EpiPen®? ☐ Yes ☐ No If "Yes," please describe when your child might need an EpiPen®:

6. Does your child have any food intolerances that require food substitutions (e.g., lactose intolerant)? ☐ Yes ☐ No
   If "Yes," please describe:

PART B: IDENTIFICATION OF MEDICATION NEEDS

7. Is your child currently taking medication? ☐ Yes ☐ No
   If "Yes," please list the medication(s) and how often your child takes the medication:

8. Will your child need to take medication while in care at the CYP? ☐ Yes ☐ No
   If "Yes," please list the medication your child will need to take while in care at the CYP:

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9. Is your child allergic to any medication(s)? ☐Yes ☐ No If "Yes," please list the medication(s) and describe the reaction that your child experiences:

PART C: OTHER NEEDS REQUIRING ASSISTANCE WHILE IN CARE

10. Check any of the following developmental needs that your child may need assistance with while in care:

☐Communication (e.g., speech/language delay)
☐Behavior (e.g., oppositional defiant disorder)
☐Learning and attention (e.g., attention-deficit hyperactivity disorder)
☐Social/emotional (e.g., anxiety disorder)
☐Developmental (e.g., autism spectrum disorder)

11. If you checked any boxes in #10 above, briefly describe the type of assistance your child will need while in care:

12. Briefly describe any other type of assistance your child will need while in care. If your child will not require any type of assistance while in care, write, "None."

PART D: EARLY INTERVENTION AND SPECIAL EDUCATION

13. Is your child receiving services through an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP)?
☐ Yes ☐ No

PART E: EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) ENROLLMENT

14. Is your child enrolled in the EFMP? ☐ Yes ☐ No

I acknowledge that all the above information is true and accurate. I understand that I must immediately report any changes in my child's health or other needs to the CYP so that the CYP Professionals can keep my child safe and healthy and provide the best possible care. Changes to my child's health information may require additional medical documentation and meeting with the Navy CYP Inclusion Action Team (IAT).

SIGN HERE

Sponsor's Signature and Date (Signature indicates the sponsor has provided true and accurate information to the best of his/her knowledge.)

SIGN HERE

CYP Professional's Signature and Date (Signature indicates the CYP Professional has reviewed the information provided on this form and will alert the CYP Director immediately to ensure any necessary accommodations are made for the child.)

This form must be reviewed by the parent(s) each year during the annual registration process. If there are no changes to be made, the parent(s) may simply initial and date the form. If there are changes to be made, a new form must be completed.

Sponsor's Initials and Date: _____ *Sponsor's Initials and Date:* _____ *Sponsor's Initials and Date:* _____ *Sponsor's Initials and Date:* _____

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 information about your child's overall health and needs that may affect his/her care at the CYP.

ROUTINE USES: Information may be furnished to military or civilian doctors or hospitals in the course of obtaining medical attention for children. The information may also be shared with members of the command Inclusion Action Team (IAT) for the purpose of identifying any accommodations your child may need.

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.

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INSTRUCTIONS

1. If your child has medical needs that require assistance while in care, answer "Yes" and check all of the boxes that apply. If any boxes are checked, an Identified Needs Intake package containing a CYP Emergency Action Plan (EAP) and a Medication Administration form (if your child will need medication while in care) completed by your child's physician is required.

2. If "Other Chronic Medical Needs" or "Physical Disability" is checked in Question #1, provide a brief description of your child's need (e.g. blindness/visual problems, hearing problems, etc.). An Identified Needs Intake package containing a CYP Emergency Action Plan (EAP) and a Medication Administration form (if your child will need medication while in care) completed by the child's physician may be required upon review.

3. Answer "Yes" if your child suffers from allergies or allergic reactions (e.g., seasonal hay fever, bee stings, hives, rashes, etc.), then list the allergies/allergic reactions. An Identified Needs Intake package containing a CYP Emergency Action Plan (EAP) and a Medication Administration form (if your child will need medication while in care) completed by the child's physician may be required upon review.

4. Answer "Yes" if your child has any food allergies. List any food allergies (see definitions at the bottom of the page) which require food substitutions. A medical statement must be completed by the child's primary physician which explains the food substitutions that are necessary to meet the child's needs.

5. Answer "Yes" if your child needs an EpiPen®, and if CYP staff may need to use it for your child. Describe the type of situation when an EpiPen® might be needed. If "Yes," an Identified Needs Intake package containing a CYP Emergency Action Plan (EAP) and a Medication Administration form completed by the child's physician is required.

6. Answer "Yes" if your child has any food intolerances (see definitions at the bottom of the page) that require food substitutions, and provide a short description of the child's food intolerance (e.g., lactose intolerant, gluten intolerant, etc.). A medical statement must be completed by the child's primary physician which explains the food subsititutions that are necessary to meet the child's needs.

7. If your child takes any medication(s), list the medication(s) your child takes and how often he/she takes the medication(s).

8. If your child will require medication(s) while in care at the CYP, answer "Yes," then list the medication(s). A Medication Administration form completed by the child's physician is required. For any conditions that require rescue medication, an Identified Needs Intake package containing a CYP Emergency Action Plan (EAP) completed and signed by your child's physician will be required.

9. Answer "Yes" if your child is allergic to any medication(s), then list the medication(s) and describe the reaction(s) your child experiences with each medication.

10. Check the boxes applicable for any other types of assistance your child may need while in care.

11. Provide a brief explanation of support your child will need while in care to address the areas answered in Question #10 (or write "None" if no other type(s) of assistance is/are needed for your child).

12. Provide a short description of any other type(s) of assistance not previously listed that your child will need while in care (or write, "None" if no other type(s) of assistance is/are required for your child).

13. Answer "Yes" if your child is receiving services based on an IFSP or IEP and provide a copy of your child's IFSP/IEP so that we can best support his/her needs.

14. Answer "Yes" if your child is enrolled in the EFMP. If "Yes," you may wish to provide the EFMP Enrollment Letter for your child's file.

Definitions:

Food Allergy: When a child has a food allergy, his/her body responds to food as if it were a threat. The body's immune system response can be mild or, in rare cases, associated with a severe and life-threatening reaction called anaphylaxis. Allergic reactions are highly unpredictable. The severity of one attack does not predict the severity of the next attack. The only way to prevent a life-threatening reaction is strict **avoidance** of the allergen.

Food Intolerance: When a child has a food intolerance, it is a reaction of the digestive system and is not dangerous. Although a child may experience gas, bloating, abdominal pain and/or diarrhea, the reactions will pass and the child is not in danger. Children with food intolerances likely do not have prescribed medications for their condition and do not need an EAP. Some common food intolerances are lactose and gluten.