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 and EO 9397 (SSN).
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 uses: In addition to those disclosures generally permitted under 5 USC 552a(b) of the Privacy Act, these records or information contained in them 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/agencies in emergency situations. The "Blanket Routine Uses" set forth at the beginning of the Army's 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	Sponsor SSN (last four digits)	Spouse's work telephone

Child Health Information

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

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

Ongoing medications

Name	Dosage	Frequency

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	
P	Right / Left /	Tested with/without glasses

	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

☐ All sports ☐ Yes ☐ No ☐ Normal physical activity to including physical education

☐ PA additional comments ☐ 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 the child requires to participate in Child, Youth, and School Services programs (to include sports).

Child/youth is able to participate in normal Child, Youth, and School Services programs? ☐ Yes ☐ No

Licensed healthcare professional stamp	Licensed healthcare professional signature	Date

Type or print name of parent or guardian	Signature of parent or guardian	Date

Health Assessment Annual Recertification

Health status changed	Signature of parent or guardian	Date
☐ Yes ☐ No		

Health status changed	Signature of parent or guardian	Date
☐ Yes ☐ No		