CHILD AND YOUTH SERVICES HEALTH ASSESSMENT/SPORTS PHYSICAL

(IMCOM-Europe Memo, IMEU-MWD-C, 10 March 2008, Subject: IMCOM-Europe Child and Youth Services Health Requirements)

Data required by the Privacy Act of 1974

Authority: 10 USC 3013 and EO 9397 (SSN).
Purpose:(1) Verify child health and status of immunization per 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 Privacy Act, these records or information contained therein may specifically be disclosed outside the 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, however, if information is not provided, individuals may not be able to participate in CYS activities or services.

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 telephone	

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. Any hospitalization or operation	☐	☐	14. Heat stroke or exhaustion	☐	☐
2. Allergies to medicine, insect bites, or food	☐	☐	15. Broken bones or sprains	☐	☐
3. Speech or development delays	☐	☐	16. Joint injuries (ankle/knee/wrist)	☐	☐
4. Vision problems (glasses/contacts)	☐	☐	17. Required restricted physical activity	☐	☐
5. Ear or hearing problems	☐	☐	18. Diabetes	☐	☐
6. Seizures or convulsions	☐	☐	19. Cancer	☐	☐
7. Dizziness or fainting with exercise	☐	☐	20. Dental or orthodontic braces	☐	☐
8. Headaches	☐	☐	21. Learning problems	☐	☐
9. Head injury or loss of conciousness	☐	☐	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. Other problems (list below)	☐	☐
13. Chest pain with exercise	☐	☐			

If you answer 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 CYS programs (to include sports).

Child/youth is able to participate in normal CYS 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 Re-Certification

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