AIR FORCE YOUTH FLIGHT PROGRAM PATRON REGISTRATION

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 8013; 44 USC 3101; EO 9397
PRINCIPAL PURPOSES: To provide Youth Flight Programs with authorization for medical treatment in emergency situations; authorization for field trips; identify children and sponsor, record required immunizations; record known allergies; record income data; record special needs requirements; and record special instructions.
ROUTINE USES: Form may be furnished to civilian doctors or hospitals in course of obtaining emergency medical attention for children. Information furnished may be disclosed, upon request, to other Federal, state or local governmental agencies in the pursuit of their official duties. Finally, it may be used for other lawful purposes including law enforcement and litigation.
DISCLOSURE IS VOLUNTARY: Failure to furnish information, including SSN, will result in denial of admission of child(ren) to Youth Flight Programs. SSN is used for positive identification of individuals and records.

CHILD'S NAME	SPONSOR *(Last, First, Middle Initial)*	SPOUSE *(Last, First, Middle Initial)*	FEES
HOME PHONE	RANK/GRADE	RANK/GRADE	DEROS/ID EXPIRES
ADDRESS	DUTY PHONE	DUTY PHONE	BRANCH OF SERVICE
	ORGANIZATION	EMERGENCY CONTACT	EMERGENCY PHONE
			HOSPITAL PHONE
MARITAL STATUS	SPONSOR'S SSN	SPOUSE'S SSN	PHYSICIAN'S NAME

VACCINE / DATE RECEIVED	BIRTH	2 MOS	4 MOS	6 MOS	12 MOS	15 MOS	18 MOS	4-6 YRS	11-12 YRS	14-16 YRS
Hepatitis B										
1st	Hep B-1									
2nd										
3rd		Hep B-2		Hep B-3					Hep B	
4th										
Diphtheria-Tetanus, Pertussis										
1st										
2nd										
3rd		DTP	DTP	DTIP	DTP			DTP OR DTAP	Td	
4th										
5th										
6th										
H.Influenzane type b										
1st										
2nd										
3rd		Hib	Hib	Hib	Hib					
4th										
Polio										
1st										
2nd										
3rd		OPV	OPV	OPV				OPV		
4th										
Measles, Mumps, Rubella										
1st					MMR			MMR OR MMR		
2nd										
Varicella Zoster Virus Vaccine										
1st						VZV			VZV	
2nd										

SEX *(X One)*: MALE / FEMALE

DATE OF BIRTH (Day, Month, Year)

I authorize emergency treatment for the children named hereon:

SIGNATURE	DATE (YYYYMMDD)

SPECIAL INSTRUCTIONS

SPECIAL NEEDS CARE /CHRONIC ILLNESSES /ALLERGIES

OTHER IMMUNIZATIONS AS REQUIRED:

VACCINE TYPE:		DATE:	
VACCINE TYPE:		DATE:	
VACCINE TYPE:		DATE:	
VACCINE TYPE:		DATE:	

NAMES OF ADDITIONAL CHILDREN ENROLLED IN PROGRAM:

ADULTS AUTHORIZED TO SIGN CHILDREN IN / OUT

AUTHORIZATION FOR FIELD TRIPS

FAMILY INCOME *(Adjusted gross--most recent 1040)*
PROVIDE ONLY IF REDUCED FEES ARE REQUESTED.
$ ________ SINGLE / DUAL INCOME *(Circle One)* $ ________

PARENT SIGNATURE

IT IS THE RESPONSIBILITY OF EACH SPONSOR TO ENSURE IMMUNIZATIONS AND EMERGENCY INFORMATION IS UP TO DATE. FAILURE TO UPDATE MAY RESULT IN REFUSAL OF SERVICE.

Asthma Action Plan

General Information:

Name____

EmergencyContact______________________PhoneNumbers__________

Physician/Healthcare Provider__________________ Phone Numbers__________

Physician Signature_____________________ Date______________

Stamp

Severity Classification	Triggers	Exercise
Intermittent Moderate Persistent Mild Persistent Sever Persistent	Colds Smoke Weather Exercise Dust Air Pollution Animals Food Other:	1. Premedication (how much and when) ____________________ 2. Exercise Modifications: ____________________

Green Zone: Doing Well

Symptoms

- Breathing is good
- No Cough or Wheezing
- Can Work and plan
- Sleeps Well

Control Medications

Medication	How much to take	When to take it

Yellow Zone: Symptoms Appear   Contact Physician if using quick relief more than 2 times per week

Symptoms

- Some problems breathing
- Cough, wheeze, or chest light
- Problems working or playing
- Wake during sleep

Continue control medications and add:

Medication	How much to take	When to take it

If symptoms return to Green Zone after on hour of quick-relief treatment, Then

Take quick-relief medication every 4 hours for 1-2 days

Change long-term control medicine by:

Contact physician for follow-up care.

If symptoms DO NOT return to Green Zone after one hour of the quick-relief treatment, Then

Take quick-relief treatment again.

Change long-term control medicine to:

Call the physician/Health care provider within

hour(s) of modifying medication routine.

Red Zone: Medical Alert   Ambulance/Emergency Phone Number

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Continue control medications and add:

Medication	How much to take	When to take it

Go to the hospital or call for an ambulance if:
Still in the red zone after 15 minutes
you have not been able to reach your physician/ healtcare provider for help.

Call an ambulance immediately if the following danger signs are present:
Trouble walking/talking due to shortness of breath.
Lips or fingernail are blue.

Statement for Special Diet Prescription - VDH

The following child is a participant in one of the United Stated Department of Agriculture (USDA) programs: National School Lunch Program School Breakfast Program, After-school Snack Program, Summer Food Service Program or the Child and Adult Care Food Program. USDA regulations 7CFR Part 15B requires substitution or modifications in school/program meals for children whose disabilities restrict their diets. A child with a disability must be supplied substitutions in food when that need is supported by a statement signed by a licensed physician. Food allergies which result in severe, life-threatening (anaphylatic) reaction, also meet the definition of "disability", and the substitutions prescribed by the licensed physician/medical authority would be made. The statement must include the following:

Part 1: To be completed by Parent/Guardian

Child's Name:

Name of School/Center/Program:

Parent's/Guardian's Name:

Home Phone	Work Phone

Address:

City, St, Zip Code:

Date of Birth: | **M** **F**

Grade Level/Classroom:

Name of School/Center/Program:

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Education Rights and Privacy Act, I hear by authorize ____________________to release such protected health information of my child as is necessary for the specific purpose of Special Diet information to ______________________ and I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child, with the school program as necessary. I understand that I may refuse to sign this authorization without impact on the eligibility of my request for a special diet for my child. I understand that permission to release this information may be rescinded at any time except when the information has already been released. My permission to release this information will expire on__________ This information is to be released for specific purpose of Special Diet information.

The Understanding certifies that he/she is the parent/guardian or representative of the person listed on this document and has legal authority to sign on behalf of that person.

Parent/Guardian Signature:______________________________

Date:________________

Part 2: To be completed by Physician/Medical Authority

Does the child have a disability?
Yes__________ No__________
If yes, please describe the major life activities affected by the disability.

Does the child have special nutritional or feeding needs?
Yes__________ No__________
If yes, complete Part 3 of this form and have it signed and stamped with the office name and address by a licensed physician/medical authority.

If the child is not disabled, does the child have special nutritional or feeding needs?
Yes__________ No__________
If yes, please see Part 3 of this form and have it signed and stamped with the office name and address by a licensed by physician/medical authority.

Does the child require emergency medication be administered?
Yes__________ No__________
If yes, please list medication(s) and describe situation/ reactions that would necessitate administrating.

Statement for Special Diet Prescription - VDH

Part 3: To be completed by Physician/Medical Authority	
List any dietary restrictions or special diet:	
List foods to be substituted (mandatory):	
List foods that need the following change in texture. If all foods need to be prepared in these manner, indicate "ALL" Cut up/chopped into bite sized pieces: Finely Ground: Pureed:	
List any special equipment or utensils needed:	
Indicate any other comments about the child's eating or feeding patterns:	
Physician's Name and Office Phone Number:	Office Stamp:
Physician/Medical Authority Signature:	Date:
Part 4: Parent's/Guardian's Signature	
Parent's/Guardian's Signature:	Date:
Part 5: Program Signature	
School/Program Official Signature:	Date:

*Please have parent/guardian review form annually and initial/date if no changes are required. Any changes require submission of a new form signed by the Physician/Medical Authority.

**MEDCOM Dietitian approved food substitution on this sheet.

Food Allergy	Essential Food Component Mission	**Food Substitutions
Apple Juice	Vitamin C, dietary fiber	100% orange, grape, grapefruit juices; no juice blends
Beef	Protein	Pork, chicken, turkey, seafood, nuts, seeds, beans, legumes, cheese, yogurt, soy based “meat“ selections
Chicken/Turkey	Protein	Beef, Pork
Dairy Products	Calcium	Soy products (cheese, yogurt)
Eggs	Protein	Cheese
Milk (Lactose Intolerant)	Calcium	Soy/Rice Milk and products/Lactose Free Milk
MSG	N/A	Garlic salt/powder, onion salt/ powder, Lawry’s seasoned salt, all other single spices
Orange Juice	Vitamin C, dietary fiber, folic acid, potassium	100% orange, grape, grapefruit juices; no juice blends
Oatmeal	Dietary fiber, folic acid, carbohydrates	Corn, potato, soy, wheat and rice flours and arrowroot starch, cereal; corn flakes, rice crispies
Peanuts/Peanut Butter/Nuts	Protein, vitamin E, niacin, folic acid	Beans, legumes, soy nut butter, cheese
Pork	Protein	Beef, chicken, turkey, seafood, nuts, seeds, beans, legumes, cheese, yogurt, tofu, soybeans, soy based “meat“ selections
Seafood	Protein	Beef, chicken, turkey, nuts, seeds, beans, legumes, cheese, yogurt, tofu, soybeans, soy based “meat“ selections
Soy Products	Protein	Beef, chicken, turkey, seafood, nuts, seeds, beans, legumes, cheese, yogurt, pork
Strawberries	Vitamin C, potassium, dietary fiber	Apples, oranges, pears, peaches, plums, melons
Tomatoes	Vitamin C	Apples, oranges, pears, peaches, plums, melons
Tomato Products	Vitamin C	Apples, oranges, pears, peaches, plums, melons
Wheat	Carbohydrates, folic acid, dietary fiber	Corn, potato, oat, soy and rice flours and cereal made from these items and arrowroot starch

MEMORANDUM FOR: Parents of Child and Youth Programs
From: 460 FSS/FSY
SUBJECT: Child and Youth Behavioral Military & Family Life Counseling (CYB-MFLC)

1. This letter is to inform you about the Child and Youth Military & Family Life Counseling (CYB-MFLC) Program Services. Due to the unique challenges faced by military families, the Department of Defense is offering this private and confidential non-medical counseling services to Service members, families, children and staff of Child and Youth Programs (CYP), Department of Defense Education Activity (DoDEA) Schools, Local Education Agencies (LEA), DoDEA CYP summer programs, National Military Family Association Operation Purple Camps, Guard/Reserve Camps, and Operation Military Kids Camps.

2. The CYB-MFLC may support staff and work with children and families in the following ways:
• Observe, participate and engage in activities with children and youth
• Provide direct interaction with children
• Model behavioral techniques and provide feedback
• Suggest courses of age appropriate behavioral interventions to enhance coping and behavioral skills
• Provide outreach to parents when they drop off or pick up their child or at family events
• Be available for parents to contact for guidance and support
• Facilitate psycho-educational groups
• Conduct training for staff and parents
• Recommend referrals to military social services and other resources as needed

3. CYB-MFLCs may assist parents, children and centers in the following ways:
Communication Self-esteem/self confidence
Resolving conflicts Behavioral management techniques
Helping children deal with their angry feelings Sibling/parental relationships
Bullying Deployment and reintegration issues

4. The counselor may also work with children in settings such as field trips and other center, camp, or school sponsored activities.

5. The counselor is available to accommodate appointments and meeting/activities after hours and on weekends with advance notice.

6. At no time will the counselor meet individually with a child without being in line of sight of a CYP, DoDEA, LEA, or camp employee or a parent/guardian.

7. The counselor may use only use OSD approved materials for trainings, groups, and any other activities.

8. With the expectation of mandatory stat, federal, and military reporting requirements (i.e., domestic violence, child abuse, and duty-to-warn situations), as well as oversight review by DoD of the service you received should an adverse or harmful event occur, MFLC support is private and confidential to encourage the widest level of participation.

I acknowledge that CYB-MFLC is available and authorize my child ______________________________
to receive CYB-MFLC support at Buckley AFB School Age/Youth/CDC/FCC Programs.

I acknowledge that CYB-MFLC is available and DO NOT authorize my child______________________
to receive CYB-MFLC support at Buckley AFB School Age/Youth/CDC/FCC Programs.

____

PARENT OR GUARDIAN SIGNATURE / DATE

Payment Authorization Form

Options for Payment:

Yes, Please place me on the Orbital Auto Pay system

No. I DO NOT wish to be placed on the Orbital Auto Pay system and will continue to pay in person or by phone. **If you choose this option, we still must have a credit card number below to be kept on file. This is in accordance with the Standard Business Policy memo dated 28 Sep 06 which reads, "parents must provide a credit card number or debit card number and agree to have their card charged or account debited for late payments."**

Please complete the information below:

I ________________________________ authorize **Orbital** to charge my credit card indicated below on the following schedule. **(Please indicate schedule below)**

Monthly for payment of my childcare fees to take place on the 1st of each month.

Bi-monthly for payment of my childcare fees to take place on the 1st and16th of each month.

Billing Address ____________________________ Phone #__________________________________

City, State, Zip ____________________________ Email____________________________________

Account Type: Visa Master Card

Cardholder Name: ____

Account Number: ____

Expiration Date: __________________ CVV (3 digit number on back of Visa/MC): ___________

SIGNATURE____ DATE__________________________

SPONSOR EMAIL ADDRESS:____

SPOUSE EMAIL ADDRESS:____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates for on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing and agree to notify the business in writing at any charges in my account information or termination of this authorization at least 15 days prior to the next billing date. This Payment authorization is for the type of bill indicated above. I certify that I am an authorize user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transaction correspond to the terms indicated in this authorization form.

CHILD DEVELOPMENT CENTER
CHILD HEALTH ASSESSMENT FORM

To be completed within 6 weeks after the child begins the program, and at least annually thereafter, to show the child is current for routine screening tests/preventive health services and immunizations according to the schedule recommended by the American Academy of Pediatrics, the Centers for Disease Control and Prevention, and the Academy of Family Practice.

FOR OFFICIAL USE ONLY. This form may contain personal medical information protected by the Privacy Act of 1974 (see AFI 33-332) and the Health Insurance Portability and Accountability Act (HIPPA) (see DoD 6025.18-R) not intended for disclosure outside government channels and exempt from mandatory disclosure under the Freedom of Information Act, 5 U.S.C., 552. Exemption 6 may apply. Title 5, U.S.C. 552a, The Privacy Act of 1974, as amended, which affords individuals the right to privacy in records maintained and used by Federal agencies. NOTE: 5 U.S.C. 552a includes Public Law (PL) 100-503, The Computer Matching and Privacy Act of 1988.

PART A: TO BE COMPLETED BY THE CHILD'S SPONSOR

CHILD'S NAME: Last, First, MI.	DATE OF BIRTH: MM/DD/YYYY
SPONSOR'S NAME: Last, First, MI.	GENDER: (circle) Male or Female

Note: Immunization information is maintained at the Program in child's records

Health history and medical information pertinent to routine child care and emergencies (describe, if any):	Allergies:
☐ None	☐ None

Is the above mentioned child covered by TRICARE for health emergencies?	Y	N		
Does the above mentioned child have health and accident insurance other than TRICARE?	Y	N	Insurance Carrier	Policy/Group#

I give permission for the authorized personnel at the ____ Child Development Center to have access to my child's health assessment information necessary for child care (to include this form).

Sponsor's Signature:	Date:

PART B: TO BE COMPLETED BY THE CHILD'S HEALTH CARE PROVIDER

HEALTH PROBLEMS OR SPECIAL NEEDS, RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE: (e.g., asthma, chronic illness, hearing or vision impairments, feeding needs, neuromuscular conditions, urinary or other ongoing health problems. (Attach additional documentation if necessary)

☐ None

HEALTH CARE PROVIDER'S STATEMENT: I have examined the above named child and/or reviewed their records and find that he/she is current for age-appropriate routine screenings, immunizations and medically able to participate in the program.

NAME OF MEDICAL CARE PROVIDER:	SIGNATURE OF MEDICAL CARE PROVIDER:

ADDRESS:	PHONE:	DATE FORM SIGNED: