UNITED STATES ARMY
CHILD & YOUTH SERVICES
Joint Base Lewis-McChord

MIAT Paperwork Quick Tips

December 2017

MIAT Paperwork Quick Tips

Things to Remember:

- Information must match and be consistent between forms (i.e. DA 7725 - Health Screening Tool, Health Assessment, Medical Action Plans, and DA 7720 - Special Diet Statements).
- A completed packet must be available, to include a DA 7725 - Health Screening Tool and Health Assessment, previous year's DA 7725 - Health Screening Tool and DA 7729 – EFMP Notes and any relevant Medical Action Plans and DA 7720- Special Diet Statements prior to Army Public Health Nurse (APHN) review.
- All Medical Action Plans (MAPs) must be completed annually (every 12 months from the date of healthcare provider's signature).
- All DA 7725 - Health Screening Tools must be completed annually (every 12 months from date of parent's signature).
- All DA 7720-Special Diet Statements (SDS) can be updated annually if there are no changes in the health plan. This can be done by the parent/guardian 12 months or before the date of the healthcare provider's signature for year two (2) and year three (3). The Special Diet Statement cannot exceed three (3) years from the date of the original healthcare provider's signature.
- All Health Assessments can be updated annually if there are no changes in the child's health. This can be done by the parent/guardian 12 months or before the date of the healthcare provider's signature for year two (2) and year three (3). The Special Diet Statement cannot exceed three (3) years from the date of the original healthcare provider's signature.
- Sports Physicals must be completed annually (every 12 months from the date of the healthcare provider's signature) and must be current through the last game of the sports season.

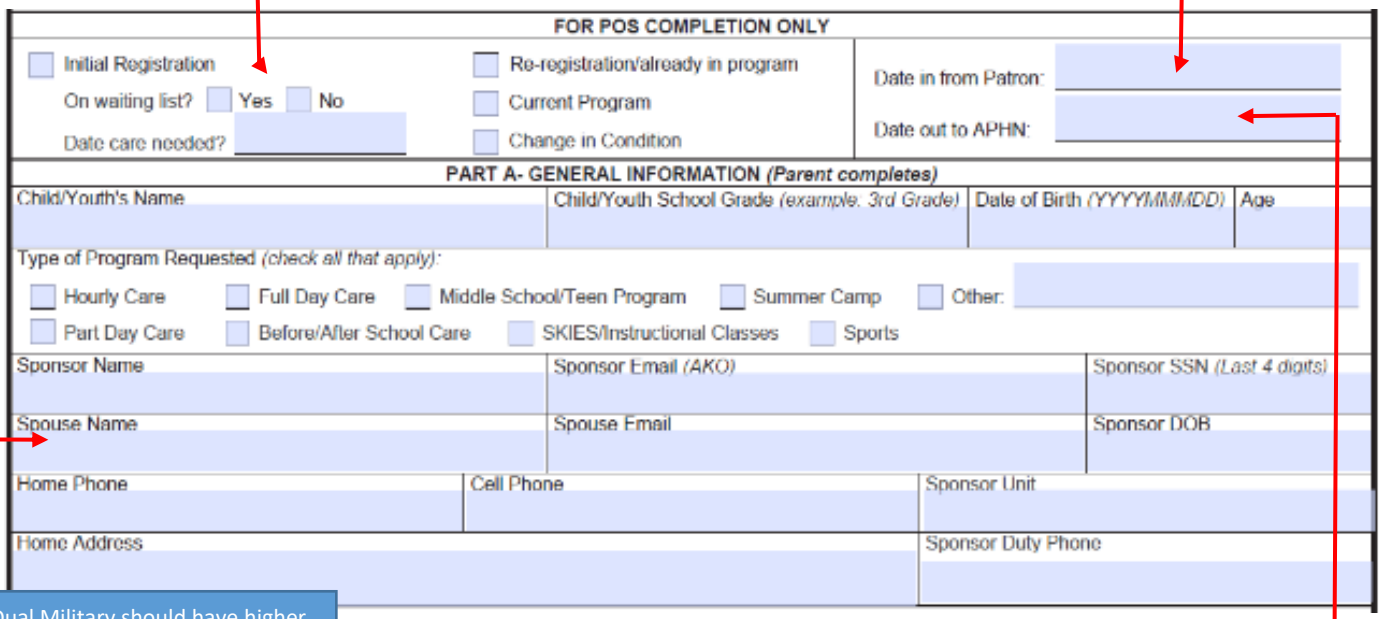
DA 7725 - Health Screening Tool

(Completed at CYS)

<Part A>

CYS staff check box according to what type of registration

Date Tool #1 was received from parent



FOR POS COMPLETION ONLY

Initial Registration
On waiting list? Yes No
Date care needed?
Re-registration/already in program
Current Program
Change in Condition
Date in from Patron:
Date out to APHN:

PART A- GENERAL INFORMATION *(Parent completes)*

Child/Youth's Name | Child/Youth School Grade *(example: 3rd Grade)* | Date of Birth *(YYYYMMMDD)* | Age

Type of Program Requested *(check all that apply)*:
Hourly Care | Full Day Care | Middle School/Teen Program | Summer Camp | Other:
Part Day Care | Before/After School Care | SKIES/Instructional Classes | Sports

Sponsor Name | Sponsor Email *(AKO)* | Sponsor SSN *(Last 4 digits)*

Spouse Name | Spouse Email | Sponsor DOB

Home Phone | Cell Phone | Sponsor Unit

Home Address | Sponsor Duty Phone

Dual Military should have higher ranking parent as sponsor

Date Tool #1 was sent to APHN for review

- FOR POS COMPLETION ONLY is completed by CYS staff
- Part A is completed by parents
- New Conditions **require a new Screening Tool #1 and Health Assessment.**
- **ALL** blocks must have complete information (i.e. Email, Home Address, etc.)
- Enter .mil email if available for easier import/export of household records in CYMS

<Part B>

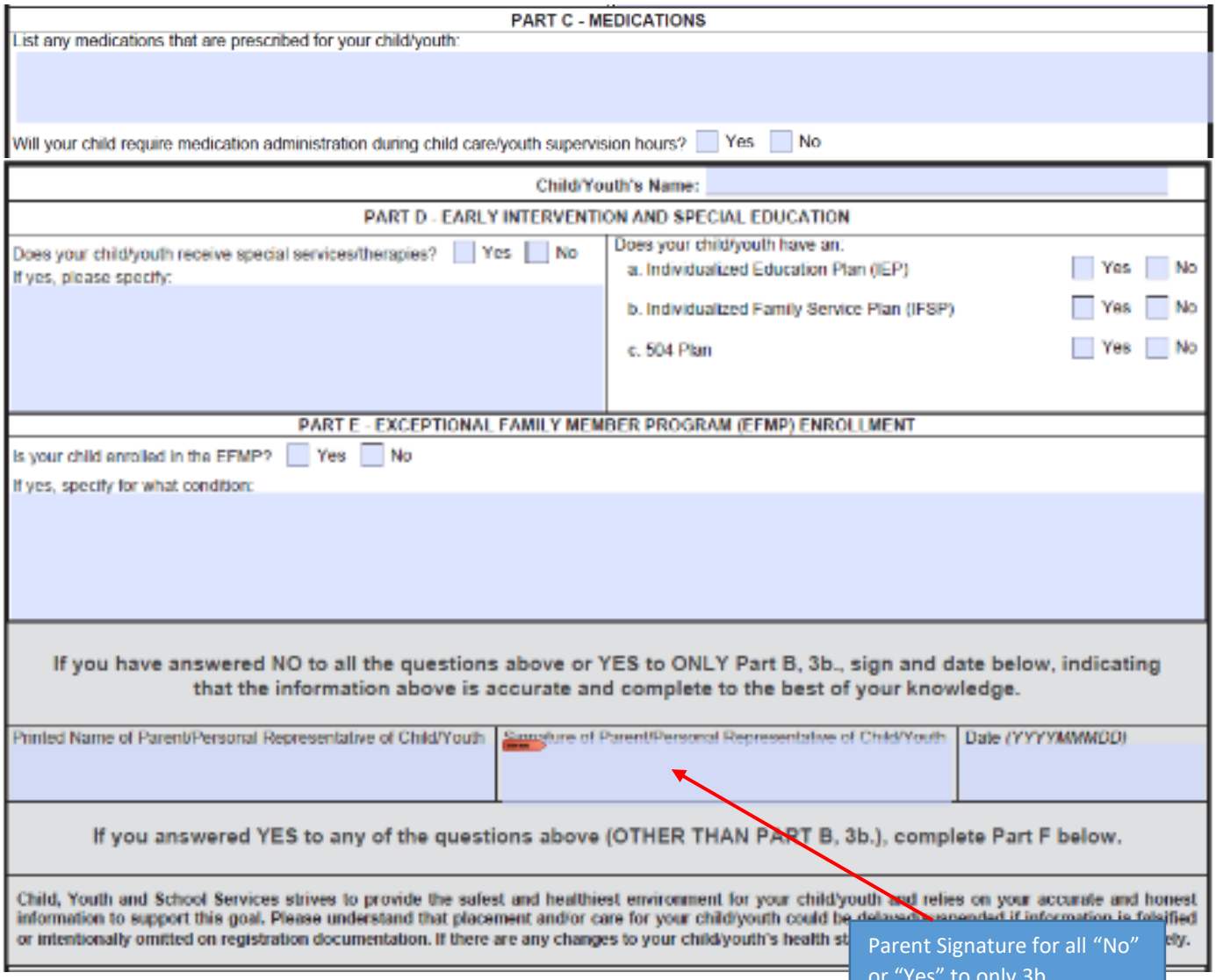
PART B - CHILD / YOUTH MEDICAL / DEVELOPMENTAL CONDITIONS *(check yes or no)*

Does your child/youth have:

1. Asthma/Reactive Airway Disease/Breathing Problems?	☐ Yes	☐ No	8. Emotional problems/difficulties?	☐ Yes	☐ No
a. Does it require a rescue medication?	☐ Yes	☐ No	9. Autism Spectrum Disorder?	☐ Yes	☐ No
2. Allergies?	☐ Yes	☐ No	10. Developmental Disability?	☐ Yes	☐ No
a. Does it require a rescue medication?	☐ Yes	☐ No	11. Visual problems/difficulties not corrected by glasses/ contacts?	☐ Yes	☐ No
3. Dietary Restrictions?	☐ Yes	☐ No	12. Hearing problems/difficulties?	☐ Yes	☐ No
☐ a. Medically-based ☐ b. Religiously-based			13. Speech/language delays?	☐ Yes	☐ No
4. Diabetes?	☐ Yes	☐ No	14. Other developmental delays?	☐ Yes	☐ No
5. Epilepsy/Seizures?	☐ Yes	☐ No	15. Physical disability?	☐ Yes	☐ No
6. Attention Deficit/Hyperactivity Disorder (ADD/ADHD)?	☐ Yes	☐ No	16. Other medical condition or concerns? If yes, please explain:	☐ Yes	☐ No
a. Is your child/youth prescribed medication?	☐ Yes	☐ No			
7. Diagnosed Behavior/Conduct concerns?	☐ Yes	☐ No			
a. Is your child/youth prescribed medication?	☐ Yes	☐ No			

- Part B is completed by parents
- If the parent answers **"Yes"** to questions **1, 2, 4, and 5**, a relevant **Medical Action Plan** (MAP) needs to be completed and returned (i.e. Allergy MAP, Respiratory MAP, etc.).
- If the parent answers **"Yes"** to question 3, a **Special Diet Statement** needs to be completed and returned.
- **All information** documented in Part B needs to **match and be consistent** with information found on the **Health Assessment, Special Diet Statement and MAPs** if applicable.
- **All questions** need to be answered either **"Yes" or "No"**.

<Part C – Part E>



PART C - MEDICATIONS

List any medications that are prescribed for your child/youth:

Will your child require medication administration during child care/youth supervision hours? Yes No

Child/Youth's Name:

PART D - EARLY INTERVENTION AND SPECIAL EDUCATION

Does your child/youth receive special services/therapies? Yes No

If yes, please specify:

Does your child/youth have an:

a. Individualized Education Plan (IEP) Yes No

b. Individualized Family Service Plan (IFSP) Yes No

c. 504 Plan Yes No

PART E - EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) ENROLLMENT

Is your child enrolled in the EFMP? Yes No

If yes, specify for what condition:

If you have answered NO to all the questions above or YES to ONLY Part B, 3b., sign and date below, indicating that the information above is accurate and complete to the best of your knowledge.

Printed Name of Parent/Personal Representative of Child/Youth | Signature of Parent/Personal Representative of Child/Youth | Date (YYYYMMMDD)

If you answered YES to any of the questions above (OTHER THAN PART B, 3b.), complete Part F below.

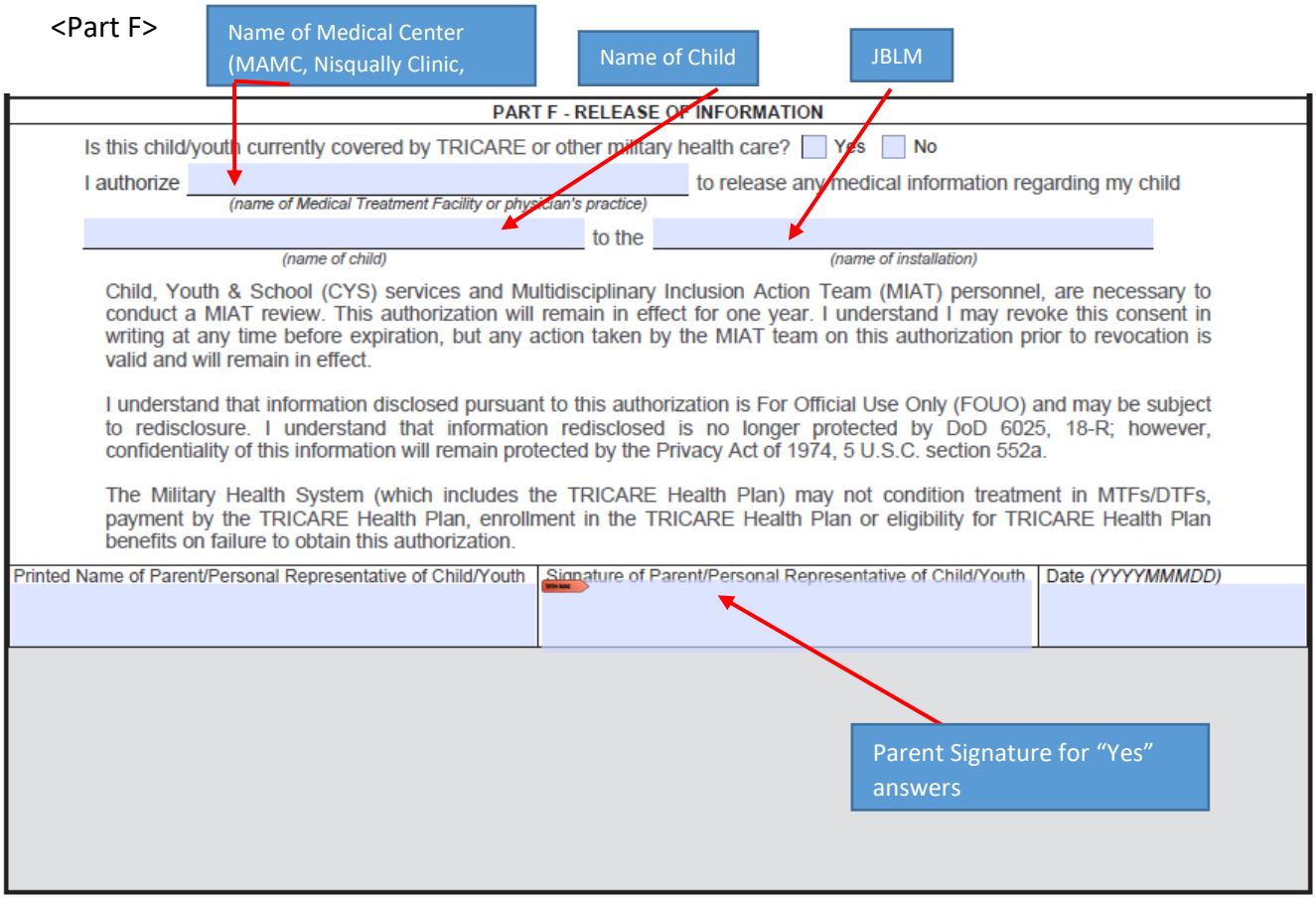
Child, Youth and School Services strives to provide the safest and healthiest environment for your child/youth and relies on your accurate and honest information to support this goal. Please understand that placement and/or care for your child/youth could be delayed, suspended if information is falsified or intentionally omitted on registration documentation. If there are any changes to your child/youth's health st ...ely.

Parent Signature for all "No" or "Yes" to only 3b

- Parts C-E are completed by parent
- Part C must include any prescribed medications and parent must indicate "Yes" or "No" for medications administered during care.

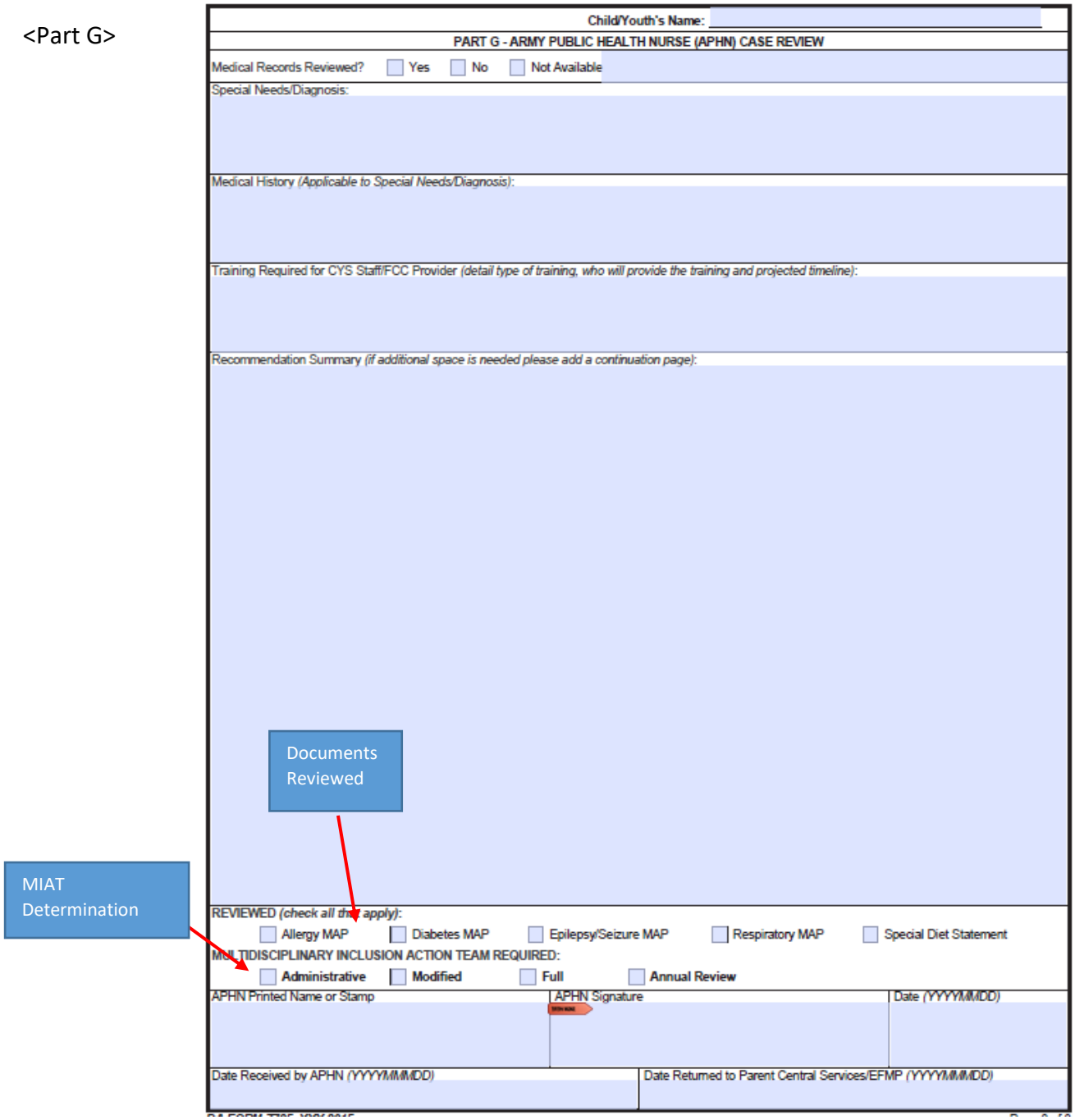
- If all answers to questions in **Part B are "No" or "Yes" to Only Part B, 3b**, **parent signs and dates Part E** for completion of the form.

<Part F>



- If any of the answers to questions in **Part B are "Yes", parent signs and dates Part F** for completion of the form.
- Form is then sent with supporting documentation (i.e. Health Assessment, MAPS, SDS) to Army Public Health Nurse for review.

<Part G>



- Part G is completed by Army Public Health Nursing (APHN)
- **APHN** reviews all submitted documentation and **completes Part G**, making a recommendation to hold a Modified, Full, Annual Review or no MIAT at all.
- Completed forms are returned to Parent Central and saved into CYMS for future use.

DA 7727 - Allergy Medical Action Plan

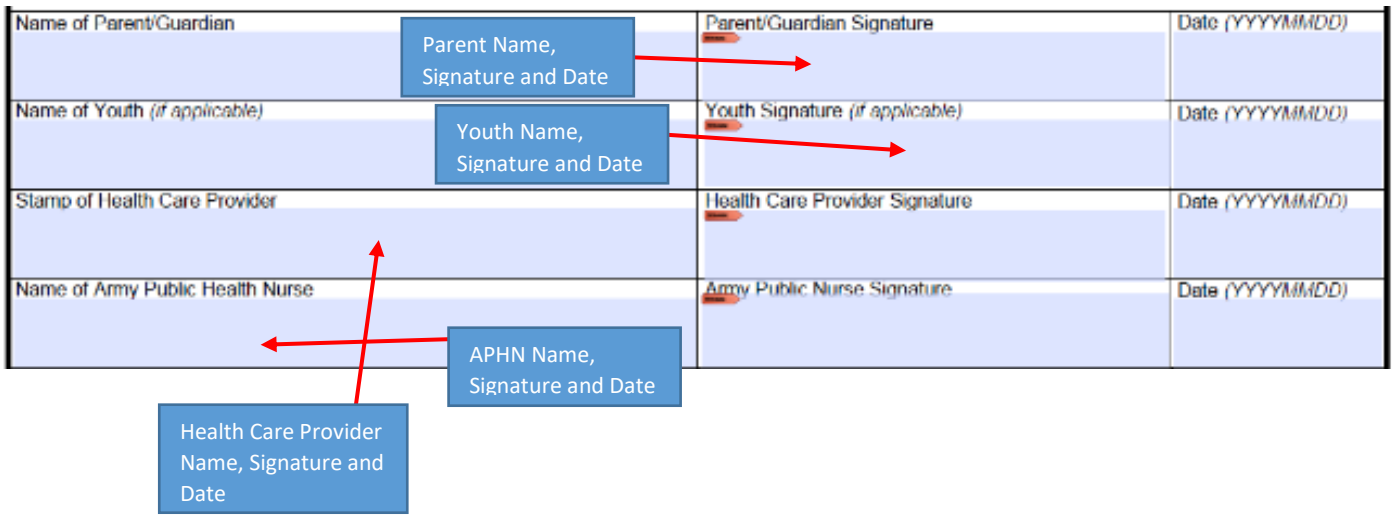
<Page 1>

Child/Youth's Name	Date of Birth	Date	Sponsor Name
Sponsor/Guardian Phone Number	Health Care Provider		Health Care Provider Phone Number

- Parent completes personal information which should be **filled out entirely**.

MEDICATION/TREATMENT PLAN		
Allergies:	Symptoms:	Medication *(as directed on prescription label)*: Can Self-Carry: ☐ Yes ☐ No Can Self-Medicate: ☐ Yes ☐ No
Allergies:	Symptoms:	Medication *(as directed on prescription label)*: Can Self-Carry: ☐ Yes ☐ No Can Self-Medicate: ☐ Yes ☐ No
Allergies:	Symptoms:	Medication *(as directed on prescription label)*: Can Self-Carry: ☐ Yes ☐ No Can Self-Medicate: ☐ Yes ☐ No

- Health care provider completes medication/treatment plan.
- Allergies that have the same symptoms and treated with the same medications may be entered on the same line, otherwise a new line entry is needed.
- Symptoms must be listed (i.e. hives, rash, difficulty breathing) or may be referred to as “Mild Symptoms” or “Severe Symptoms” which are listed on page 2 of the MAP.
- **Dose, time and route** are indicated **on the medication prescription label** and **not on** the Medication Protocol section of the Allergy MAP.
- **Medications** listed in the in **the Treatment Plan** must match medications listed in **any other documents** (i.e. Special Diet Statement, Health Assessment, Tool #1).
- **Self-Carry and Self-Medicate** indicates if the child can self-carry and self-administer their rescue medication. This section is **only applicable for School Age Children and Youth**.



- Parent must print name, sign and date.
- School Age Children and Youth who have been given authorization to self-carry, self-administer must print name, sign and date.
- Health Care Provider must stamp, sign and date.
- Army Public Health Nurse (APHN) must print, sign and date.
- **All signatures** are **required** or the form is not complete.
- This form is only **valid for 12 months** from the **health care provider's signature** and **date**.

DA 7718 - Respiratory Medical Action Plan

< Page 1>

Child/Youth's Name	Date of Birth	Date	Sponsor Name

Sponsor/Guardian Phone Number	Health Care Provider	Health Care Provider Phone Number

- Parent completes personal information which should be **filled out entirely.**

ASTHMATIC RESPIRATORY TRIGGERS ***(Check all that apply)***

☐ Animal Dander ☐ Dust ☐ Mold ☐ Pollen ☐ Tobacco Smoke ☐ Cold Air

☐ Vacuum Cleaning ☐ Strong Odors/Sprays ☐ Medication ☐ Other: _____

- The health care provider must indicate **all respiratory triggers**.

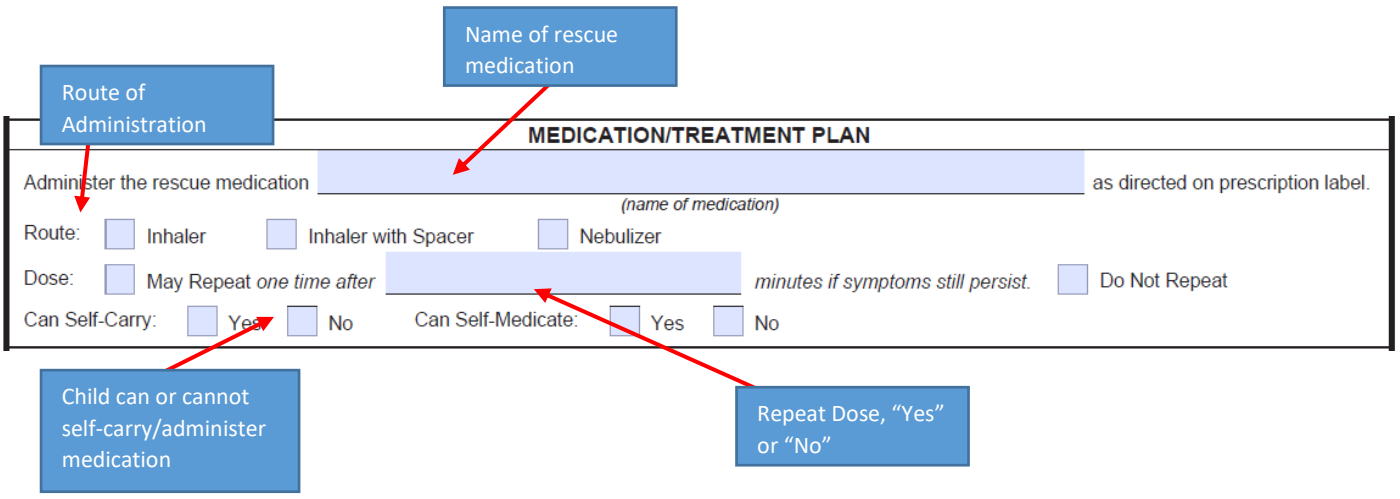
RESPIRATORY SYMPTOMS ***(Check all that apply)***

☐ Excessive dry cough ☐ Shortness of breath ☐ Tightness in the chest

☐ Mild chest retraction *(child is "pulling in" chest while breathing)* ☐ Wheezing *(a whistling sound when the child breathes)*

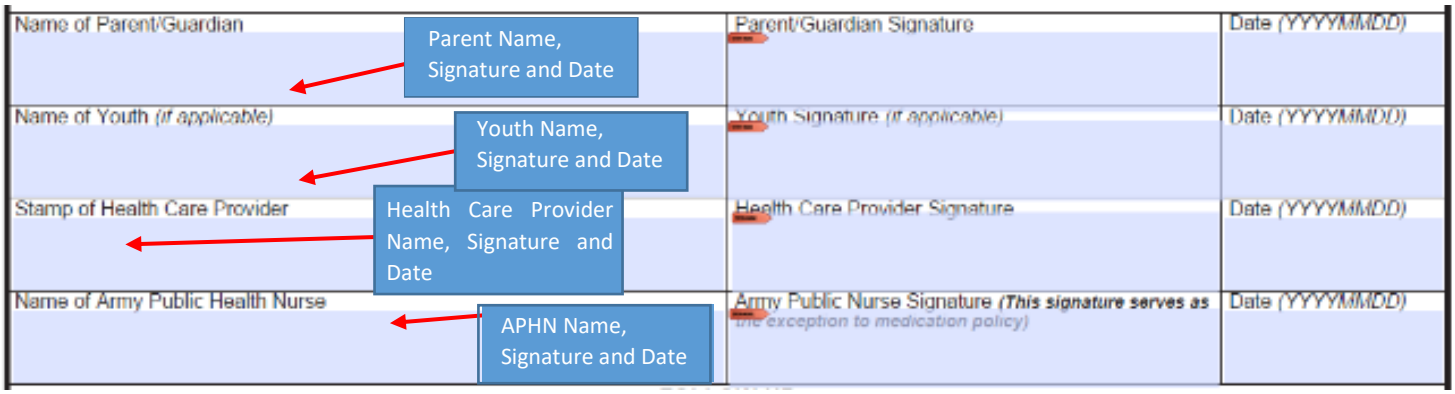
☐ Other: _____ ☐ Other: _____

- The health care provider must indicate **all symptoms** that would indicate the need for rescue medication administration.



December 2017

- The health care provider must list the **name of the rescue medication** (i.e. Albuterol or Levalbuterol) as well as the **route it is to be administered**.
- **Dose, time and route** are indicated on the **medication prescription label** and **not on** the Medication Protocol section of the Respiratory MAP.
- The route documented should only be one route, not multiple.
- The health care provider must indicate whether the medication **can be repeated** and if so, in **how many minutes** after the first dose.
- Self-Medication indicates if the child can self-carry and self-administer their rescue medication. This section is only applicable for School Age Children and Youth.



- Parent must print name, sign and date.
- School Age Children and Youth who have been given authorization to self-carry, self-administer must print name, sign and date.
- The health care provider must stamp, sign and date.
- Army Public Health Nurse (APHN) must print, sign and date.
- **All signatures** are **required** or the form is not complete.
- This form is only **valid for 12 months** from the **health care provider's signature** and **date**.

DA 7717 - Seizure Medical Action Plan

Child/Youth's Name	Date of Birth	Date	Sponsor Name

Sponsor/Guardian Phone Number	Health Care Provider	Health Care Provider Phone Number

- Parent completes personal information which should be **filled out entirely.**

EPILEPSY/SEIZURE PLAN		
Epilepsy/Seizure Diagnosis	Child/Youth's age at diagnosis	Frequency of seizures over the last 12 months
Current Treatment Regimen		

- The health care provider must indicate the child's history of **febrile seizures and/or epilepsy,** and the current treatment regimen.

EPILEPSY/SEIZURE SYMPTOMS			
☐ Lip Smacking	☐ Falling Down	☐ Rigidity Stiffness	☐ Blue Color to Lips
☐ Eye Rolling	☐ Shallow Breathing	☐ Froth from Mouth	☐ Loss of Consciousness
☐ Staring	☐ Twitching	☐ Thrashing/Jerking	☐ Other:
History of Febrile Seizures *(explain)*			

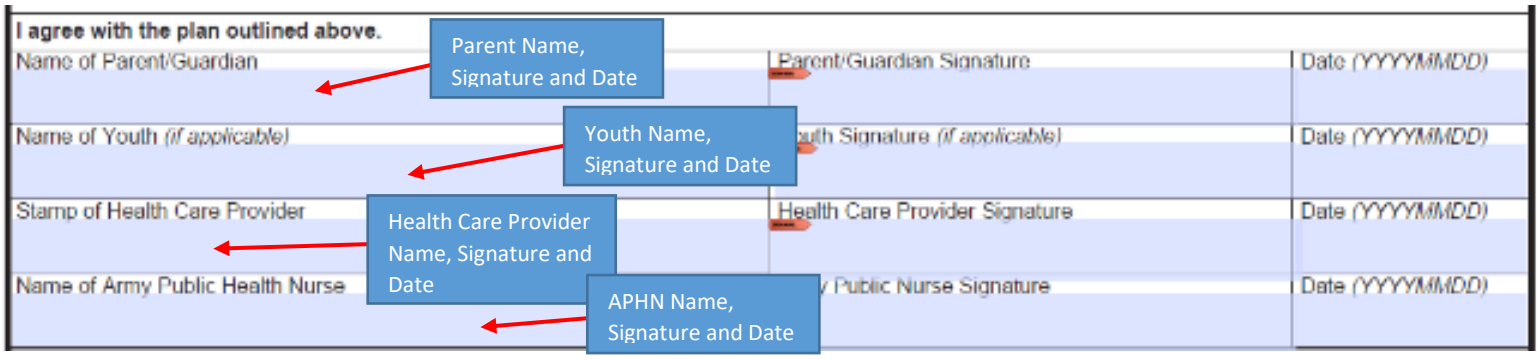
- The health care provider must indicate **all symptoms** for seizures, either febrile or epileptic, as well as a history or febrile seizures.

EPILEPSY/SEIZURE MEDICATIONS
Medication *(as directed on prescription label)*
Form Febrile Seizures temperature of _____ call Parent for Pick-Up.
Medication for immediate use in case of seizure as directed on prescription label. *(May require an exception to policy)*

Febrile seizure medication and temp to be given

Rescue Med to be given for seizure

- Medications for febrile seizure (i.e. Tylenol or Motrin) if prescribed, as well as what temperature requires the child to be picked up from care.
- Rescue medications given in the event of a seizure are listed as well (i.e. Diastat, Versed)
- **Dose, time and route** are indicated on the **medication prescription label** and **not on** the Medication Protocol section of the Seizure MAP.



- Parent must print name, sign and date.
- School Age Children and Youth who have been given authorization to self-carry, self-administer must print name, sign and date.
- The health care provider must stamp, sign and date.
- Army Public Health Nurse (APHN) must print, sign and date.
- **All signatures** are **required** or the form is not complete.
- This form is only **valid for 12 months** from the **health care provider's signature** and **date**.

Diabetes Daily Medical Action Plan

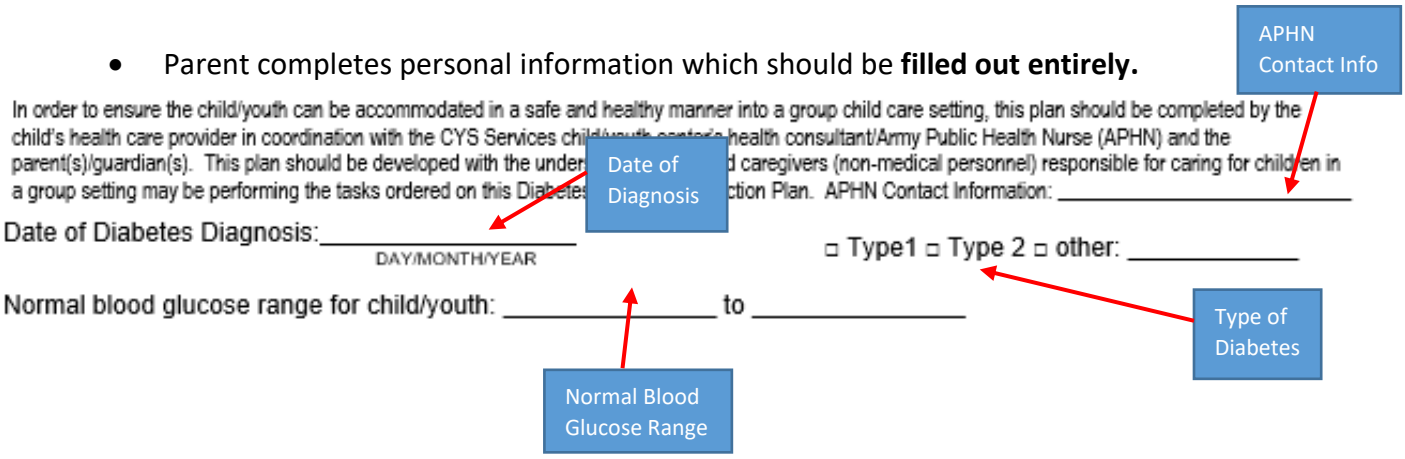
<Page 1>

PILOT - CYS SERVICES DIABETES DAILY MEDICAL ACTION PLAN

(Form to be completed by Health Care Provider)

Child/Youth's Name	Date of Birth	Date
Sponsor Name		
Health Care Provider	Health Care Provider Phone	

- Parent completes personal information which should be **filled out entirely.**



DAILY CARE REQUIREMENTS (required during child care hours)

□ Food Monitoring □ Blood Glucose Monitoring □ Activity Monitoring □ Insulin Therapy

□ Other: _____

Storage of Diabetic Supplies and Emergency Response Medications (all supplies and medications supplied by parent/guardian)

□ Blood Glucose Meter & Test Strips □ Ketone Meter & Test Strips □ Lancets □ Glucagon □ Insulin Pen □ Insulin Vial & Syringe

- The form must indicate what type of daily care will be provided to include food, blood glucose and activity monitoring as well as insulin therapy.
- **All diabetic supplies** indicated must be **supplied by the parent/guardian**.

FOOD MONITORING - OVERSIGHT BY STAFF

- ☐ Meal/Snack Portion Control
  - ☐ Verification of serving size
  - ☐ Verification of amount of food consumed
- ☐ Documentation on Food Log
- ☐ Verification of accuracy of counting of carbohydrates
- ☐ Verification of carb data entry into insulin pump
- ☐ Other: _____

- This section indicates the type of food monitoring oversight should provide.
- **Staff** are **providing oversight and verification**, not performing the tasks themselves.

BLOOD GLUCOSE MONITORING

Check blood glucose:
- ☐ Before Activity
- ☐ Before Meals/Snacks
- ☐ After Activity
- ☐ _____ Hours After Meals/Snacks
- ☐ Prior to leaving care

- Times that blood glucose levels are to be checked throughout the day need to be clearly marked.

Blood Glucose Meter with Lancets

Blood Glucose Monitor with Alarm

BLOOD GLUCOSE MONITORING – METER, LANCETS AND TEST STRIPS / CONTINUOUS GLUCOSE METER

☐ **Yes** - Brand/Model of the blood glucose meter: _____

Preferred testing site: ☐ Fingertips ☐ Forearm ☐ Thigh ☐ Other: _____

Note: If severely low blood glucose (hypoglycemia) is suspected only use the fingertips to check blood glucose.

☐ **No** - Child/Youth has a Continuous Glucose Meter (CGM) - Brand/Model: _____

Alarms set for: Low: _____ (mg/dl) High: _____ (mg/dl)

☐ Take action based on alarms and readings

☐ Confirm CGM results with a finger stick check before taking action based on CGM blood glucose readings.

Note: If child/youth has symptoms or signs of hypoglycemia, check finger stick blood glucose level regardless of CGM readings.

- If the child has a glucose meter and needs to have their blood glucose levels checked by using a lancet and test strip, "Yes" must be checked.
- If the child has a continuous glucose meter that will monitor their blood glucose levels, "No" must be checked.

BLOOD GLUCOSE MONITORING – CHILD/YOUTH SELF-ADMINISTERING/MONITORING

- ☐ **No** - CYSS Caregivers will need to perform and monitor blood glucose/ketone checks
- ☐ **Yes with assistance**, child/youth can perform and self-monitor blood glucose/ketone checks with CYSS staff assistance
- ☐ **Yes independently**, child/youth can independently perform and self-monitor blood glucose/ketone checks and can alert CYSS staff if assistance is required
- ☐ **Child/Youth** has permission to carry self-monitoring items (meter, lancets, and test strips) and can responsibly maintain and dispose of lancets

- This section is used to determine if the child can self-carry, self-administer or if they need assistance from staff. Section should be checked accordingly to child's skill level.

<Page 2>

Method of Injection

Site of Injection

INSULIN THERAPY – CHILD/YOUTH OVERSIGHT BY STAFF

Given by: ☐ Insulin Pump ☐ Syringe & Vial ☐ Insulin Pen

Administered by: ☐ Child/Youth ☐ Parent ☐ Other: _____

Preferred Injection Site: ☐ Stomach ☐ Upper Arm ☐ Thigh ☐ Buttocks ☐ Rotation ☐ Other: _____

Note: For rotation of injection sites, please ensure all preferred sites are selected.

Who can Administer Insulin

- This section is documents how insulin is given either by insulin pump, syringe and vial or insulin pen.
- Insulin can only be administered by the child/youth or parent. Staff may not administer insulin, but may provide oversight.
- Also noted is the preferred injection site for the insulin to be administered.

Symptomatic Blood Glucose Level Insulin Dosing: Give insulin according to the dosing scale:

Blood glucose _____ to _____ mg/dl give _____ units of insulin

Blood glucose _____ to _____ mg/dl give _____ units of insulin

Blood glucose _____ to _____ mg/dl give _____ units of insulin

- Insulin dosing scale based on symptoms is meant as guidance for the child/youth or parent when correcting blood glucose levels.

How meals are provided

Insulin Dosage Based on Carbohydrate Consumption

Post-meal dosing of insulin is preferred. Age and maturity must be considered when determining whether pre-meal dosing is appropriate for the child in a child care setting. Insulin dosing based on carbohydrate counts will only be supported for scheduled meals and snacks:

☐ Meal provided by parent/guardian pre-labeled amount of carbohydrates. ☐ Army CYS Standardized Menu with Nutritional Data (check availability)

☐ **Carbohydrate coverage only**: 1 unit of insulin per ____ grams of carbohydrate

☐ **Carbohydrate coverage + correction factor dose**: Pre-meal blood glucose greater than ____ mg/dl (target blood glucose) and ___ hours since last insulin dose. Correction Factor: 1 unit of insulin per ____ mg/dl above target blood glucose + 1 unit of insulin per ____ grams of carbohydrate

☐ **Insulin Pump Wizard**

☐ DO NOT give insulin for snacks.

☐ Other: _____

Child/Youth can determine own insulin dosages:

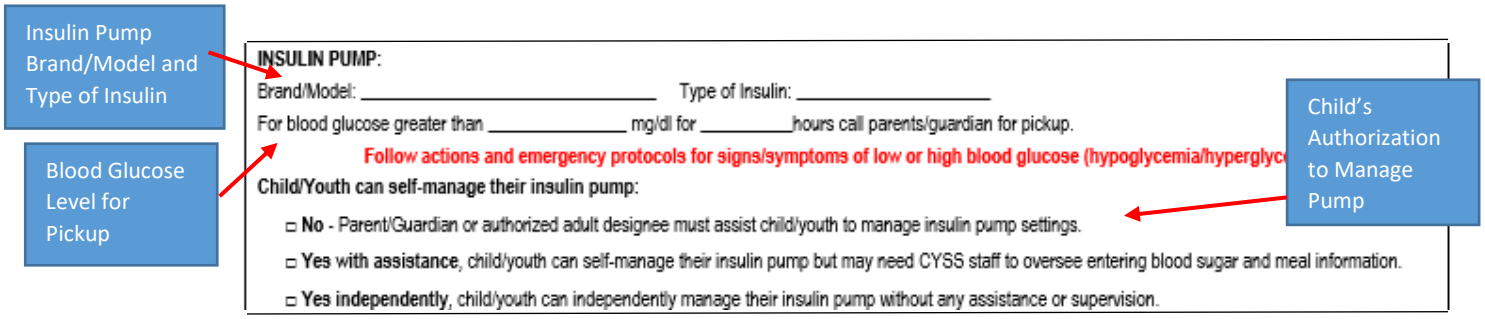
☐ **No** - Parent/Guardian or authorized adult designee must determine dosage and administer insulin injections.

☐ **Yes with assistance**, child/youth can determine dosage and administer insulin with supervision.

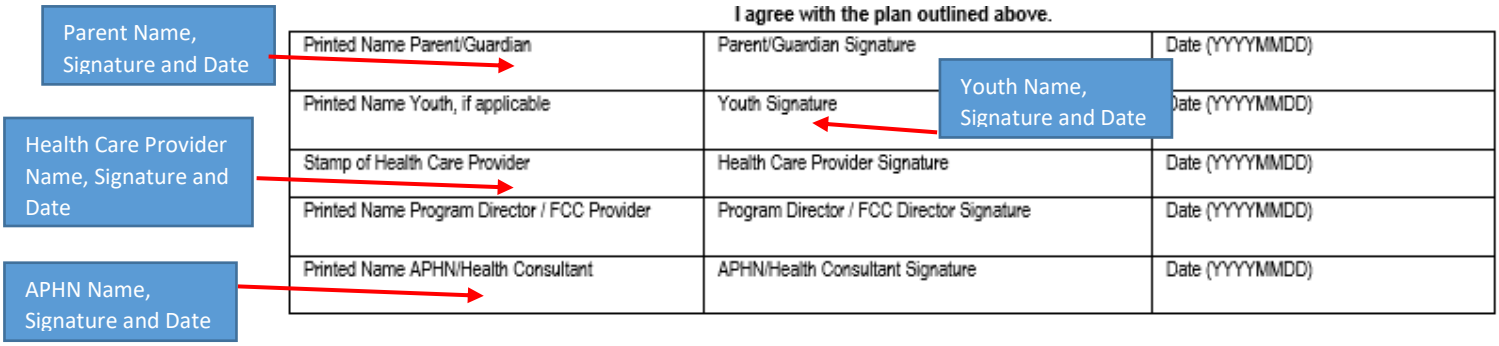
☐ **Yes independently**, child/youth can independently determine dosage and administer insulin without assistance or supervision.

Child's Authorization to Calculate Insulin Dosage

- Meals will be provided by parent/guardian and pre-labeled with amount of carbohydrates –OR- child will eat food served in the facility as documented on the Army CYS Standardized Menu.
- Units of insulin to be given based on carbohydrate consumption are calculated either for coverage only –OR- based on pre-meal blood glucose and hours since last insulin dose.
- Authorization for child to calculate own insulin dosages with or without supervision – OR- parent/guardian must determine dosage.



- Brand and model of insulin pump as well is indicated
- Blood glucose levels greater than the number indicated as well as longer than the hours indicated means the child must be picked up by parents/guardian.
- Authorization for child to calculate self-manage their insulin pump with or without supervision –OR- parent/guardian must assist with pump settings.



- Parent must print name, sign and date.
- School Age Children and Youth who have been given authorization to self-carry, self-administer must print name, sign and date.
- The health care provider must stamp, sign and date.
- Army Public Health Nurse (APHN) must print, sign and date.
- **All signatures** are **required** or the form is not complete.
- This form is only **valid for 12 months** from the **medial provider's signature** and **date**.

Diabetes Emergency Medical Action Plan

<Page 1>

PILOT - CYS SERVICES DIABETES EMERGENCY MEDICAL ACTION PLAN

(Form to be completed by Health Care Provider)

Child/Youth's Name	Doe, Jane	Date of Birth	20090214	Date	20171201
Sponsor Name	Doe, John				
Health Care Provider	Dr. Knows Best	Health Care Provider Phone	253-112-1112		

- Parent completes personal information which should be **filled out entirely.**

APHN Contact Info

In order to ensure the child/youth can be accommodated in a safe and healthy manner into a group child care setting, this plan should be completed by the child's health care provider in coordination with the CYS Services child/youth center's health consultant/Army Public Health Nurse (APHN) and the parent(s)/guardian(s). This plan should be developed with the understanding that child caregivers (non-medical personnel) responsible for caring for children in a group setting may be performing the tasks ordered on this Diabetes Emergency Medical Action Plan. APHN Contact Information: _____

Normal blood glucose range for child/youth: _____ to _____

Normal Blood Glucose Range

Hypoglycemia - Mild to Moderate, blood glucose levels below 70 mg/dl and child is able to swallow (Low Blood Sugar) Symptoms		
☐ Shakiness	☐ Irritable/Confused	☐ Weak
☐ Pale or flushed face	☐ Looks dazed	☐ Hungry
☐ Sweaty	☐ Headache	☐ Dizzy
☐ Other: _____		

- The health care provider must indicate **all symptoms** for hypoglycemia (low blood sugar level) specific to each child.

Treatment of Hypoglycemia (if child is unresponsive, or unable to swallow – initiate EMERGENCY RESPONSE)

1) If blood glucose is between _____ and _____ and child/youth is able to swallow give:
   - □ 3-4 glucose tablets
   - □ 15 gm glucose gel
   - □ A small cup of regular juice or soda (4 ounces)
   - □ Other: _____

Repeat blood glucose level in 15 minutes

2) If blood glucose is between _____ and _____ and child/youth is able to swallow, repeat food items per step 1.

Repeat blood glucose level in 15 minutes

3) If blood glucose remains between _____ and _____, repeat food items per step 1 and contact parents for pickup for non-response of blood glucose levels.

If after steps 1-2 child/youth blood glucose is below _____ and/or for signs/symptoms of severely low blood glucose:

UNCONSCIOUS, UNRESPONSIVE, OR SEIZURES - CONDUCT EMERGENCY RESPONSE PROTOCOL!

EMERGENCY RESPONSE: SEVERELY LOW BLOOD GLUCOSE REQUIRES IMMEDIATE ACTION	**Notify Emergency Medical Services and notify parent/guardian.** **□ Administer Glucagon (as prescribed)**

- **Treatment of hypoglycemia** and the child is **responsive** and **able to swallow** are indicated specific to individual blood ranges.
- **Administration of Glucagon** may also be indicated for treatment of severely low blood sugar levels, **unconsciousness, unresponsiveness or seizures**.

Hyperglycemia - Mild to Moderate, blood glucose greater than 300 mg/dl (High Blood Sugar) Symptoms

□ Frequent Urination	□ Nausea / Stomach ache	□ Heavy breathing
□ Extreme Thirst	□ Warm/dry flushed skin	□ Headache
□ Unable to Concentrate	□ Combative behavior	□ "Feels low"
□ Other: _____		

- The health care provider must indicate **all symptoms** for hyperglycemia (high blood sugar level) specific to each child.

Treatment of Hyperglycemia

If blood glucose is between _____ and _____ monitor for symptoms and check blood glucose per daily care plan.

If blood glucose is between _____ and _____:
- □ Give child/youth _____ cups of water per hour.
- □ Check □ Urine □ Blood ketones every _____ hour(s).
- □ Other: _____

Repeat blood glucose level in _____ minutes

If blood glucose is between _____ and _____ give an additional dose of insulin of _____ units.

Repeat blood glucose level in _____ minutes

If blood glucose is between _____ and _____ notify parents/guardian for pick-up

For signs/symptoms of severely high blood glucose (hyperglycemia):

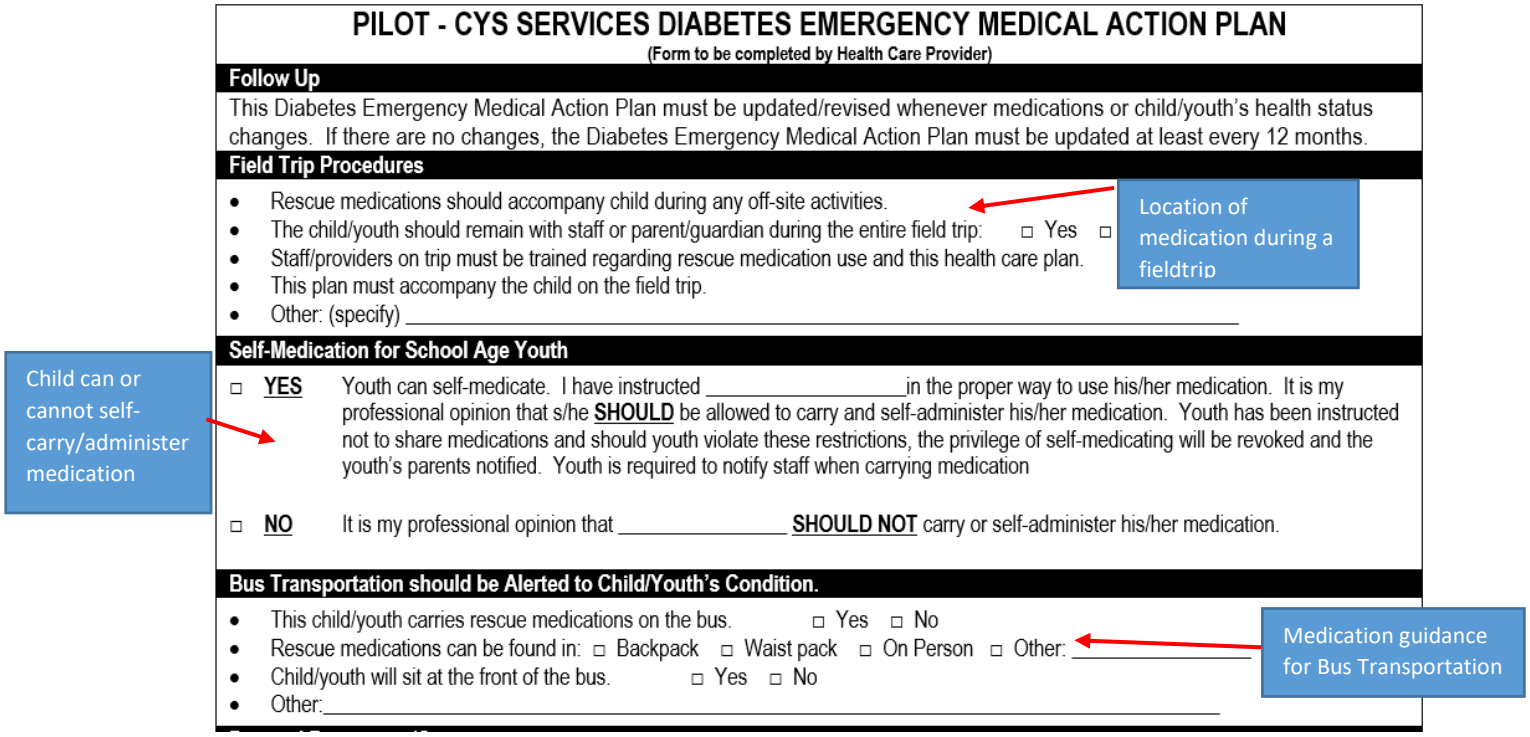
SHORTNESS OF BREATH, VOMITING, BLOOD KETONES OF _____, OTHER: _____

CONDUCT EMERGENCY RESPONSE PROTOCOL

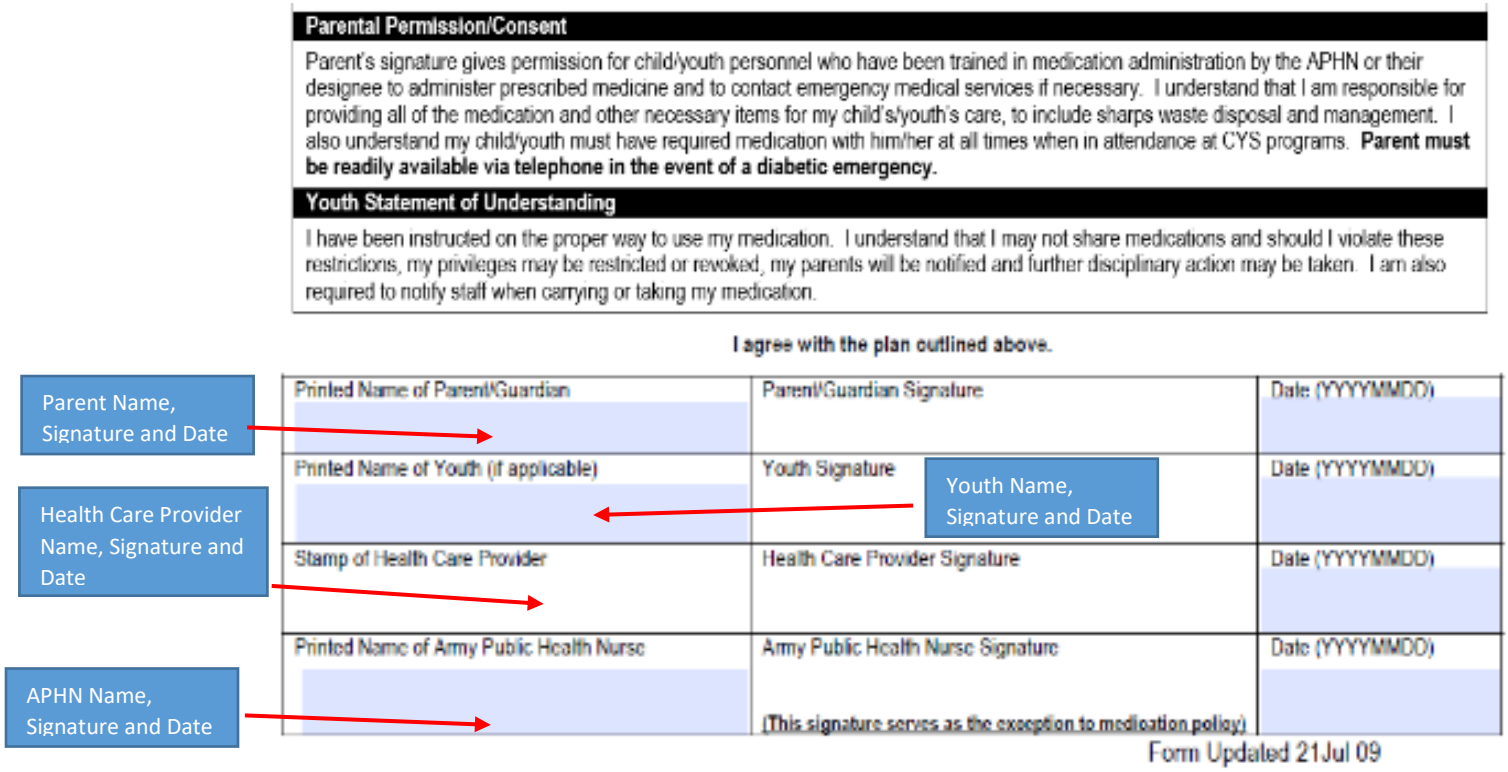
EMERGENCY RESPONSE: SEVERELY HIGH BLOOD GLUCOSE REQUIRES IMMEDIATE ACTION	**For blood sugar above _____, Notify Emergency Medical Services and notify parent/guardian.** **Additional Instructions:**

- **Treatment of hyperglycemia** is specific to individual blood ranges and addresses doses of **insulin** related to ranges of blood glucose levels.
- **Shortness of Breath, Vomiting, Blood Glucose Levels above Documented Number or Blood Ketone** levels as indicated requires **emergency medical services**.

<Page 2>



- Field Trip Procedures indicates if the child must remain with staff for the entire trip.
- Self-Medication indicates if the child can self-carry and self-administer their rescue medication. This section is only applicable for School Age Children and Youth.
- Bus Transportation indicates if the child will carry medication on the bus and where it is located.



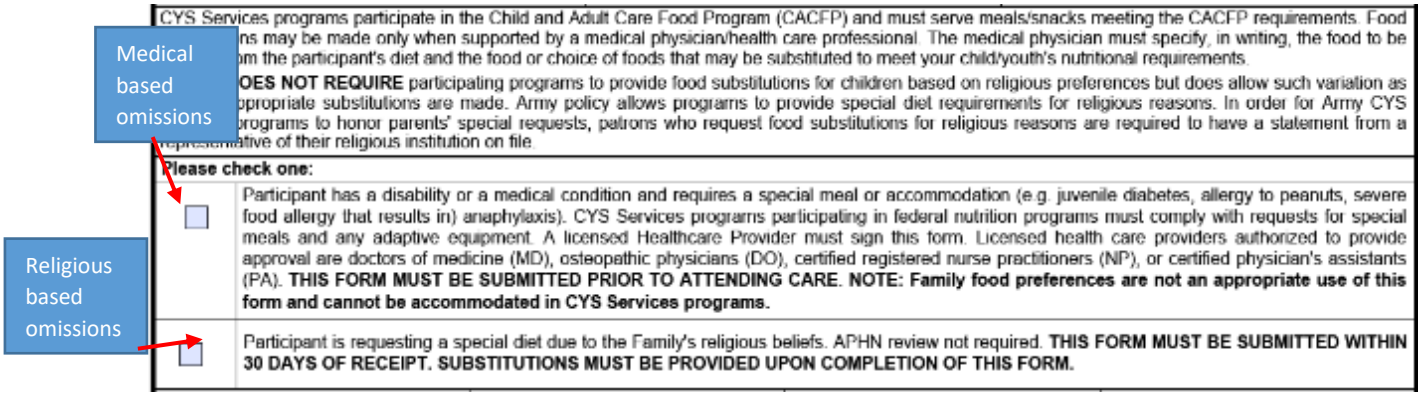
- Parent must print name, sign and date.
- School Age Children and Youth who have been given authorization to self-carry, self-administer must print name, sign and date.
- Health Care Provider must stamp, sign and date.
- Army Public Health Nurse (APHN) must print, sign and date.
- **All signatures** are **required** or the form is not complete.
- This form is only **valid for 12 months** from the **health care provider's signature** and **date**

DA 7720 - Special Diet Statement

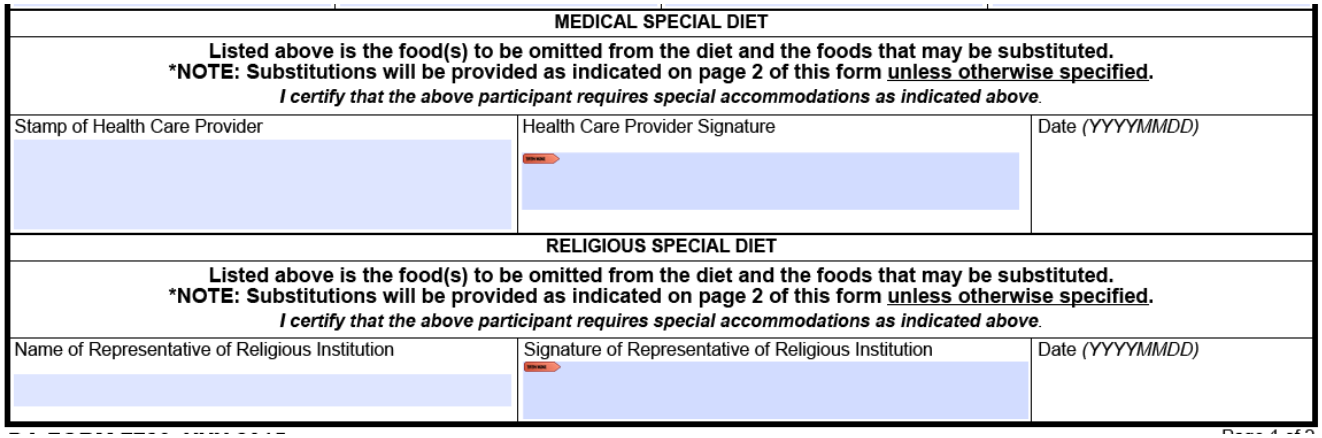
<Page 1>

Child/Youth's Name	Date of Birth	Sponsor Name	Date
Doe, Jane	20150214	Doe, John	20171201
Sponsor/Guardian Phone Number	**Health Care Provider**	**Health Care Provider Phone Number**	
253-111-1111	Dr. Knows Best	253-112-1112	

- Parent completes personal information which should be **filled out entirely.**



- Form is applicable for medical based allergies, intolerances, special food preparation or religious beliefs.
- Personal preferences cannot be accommodated by CYS.



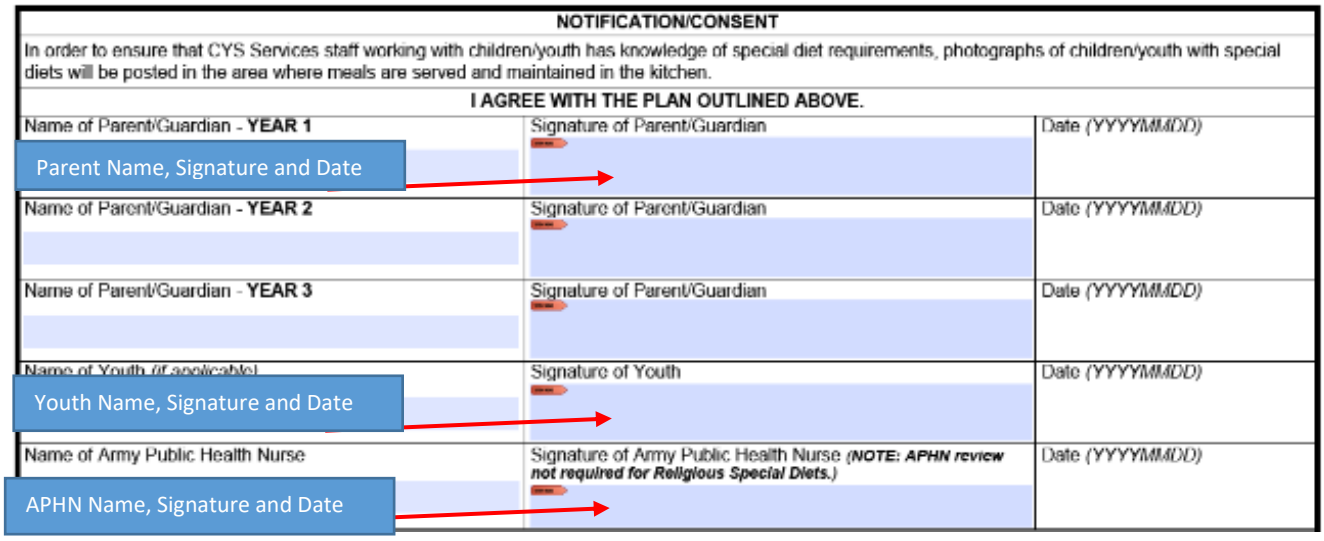
- If omissions are medically based, a health care provider must stamp, sign and date the form.
- If omissions are religiously based, a representative of that religion must sign and date the form.

Foods to be omitted	Reaction *(if applicable)*	*Authorized Substitutions	Additional Information (i.e. EPI-pen intervention, special food preparation)

- Foods that are being omitted or may be grouped together as long as the reactions, substitutions and medications (if applicable) are the same.
- A reaction must be included for medical based omissions and may be included for religious based omissions if applicable.
- MEDCOM Dietician approved food substitutions are listed on page 2 and will be used if no substitution is indicated on page 1.
- Substitutions cannot state "None", "N/A".

**MEDCOM DIETICIAN APPROVED FOOD SUBSTITUTIONS		
Foods Allergy	**Essential Food Component Missing**	****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, seafood, nuts, seeds, beans, legumes, cheese, yogurt, soy based "meat" selections
Dairy Product	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% apple, 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, 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

- Additional information is used to indicate rescue medication intervention, special dietary needs such as “pureed food” or “extra caloric intake” at meals.
- If a rescue medication is listed in additional information, an Allergy Medical Action Plan must also be completed.
- <Page 2>



NOTIFICATION/CONSENT		
In order to ensure that CYS Services staff working with children/youth has knowledge of special diet requirements, photographs of children/youth with special diets will be posted in the area where meals are served and maintained in the kitchen.		
I AGREE WITH THE PLAN OUTLINED ABOVE.		
Name of Parent/Guardian - **YEAR 1**	Signature of Parent/Guardian	Date *(YYYYMMDD)*
Name of Parent/Guardian - **YEAR 2**	Signature of Parent/Guardian	Date *(YYYYMMDD)*
Name of Parent/Guardian - **YEAR 3**	Signature of Parent/Guardian	Date *(YYYYMMDD)*
Name of Youth *(if applicable)*	Signature of Youth	Date *(YYYYMMDD)*
Name of Army Public Health Nurse	Signature of Army Public Health Nurse ***(NOTE: APHN review not required for Religious Special Diets.)***	Date *(YYYYMMDD)*

- Parent must sign Year 1 and may renew if there are no changes to dietary plan for Years 2 – 3. This is done on an annual basis with a parent signature on or before the date of the health care provider.
- Youth may also sign the form if applicable.

Health Assessment/Sports Physical

<Page 1>

PART: A Medical History (Filled out by parent / guardian)

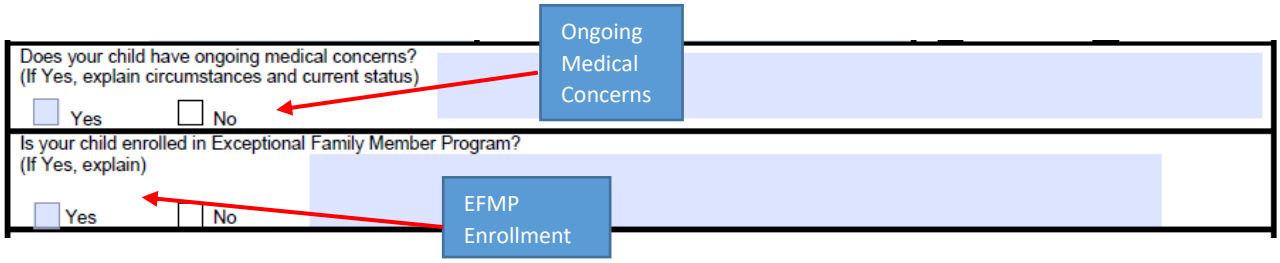
Name of Sponsor	Home Telephone / Cell Telephone	Duty/Work Telephone
Doe, John	123-456-7890 / 234-567-8901	253-111-1111

Sponsor Unit / Work Address	Sponsor SSN	Spouse's Work Telephone
Depot	xxx-xx-xxxx	253-000-0000

CHILD HEALTH INFORMATION

Name of Child	Birth Date	Sex
Doe, Jane	20150214	☐ Male ☒ Female

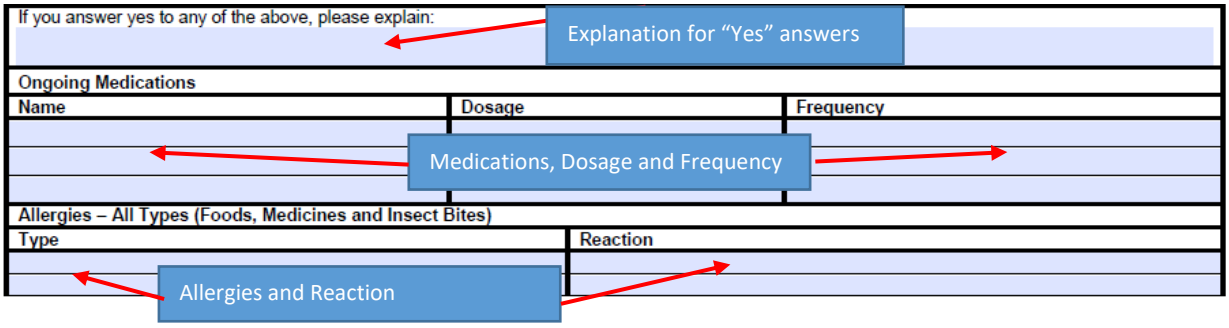
- **Part A** of the Health Assessment must be **filled out by the parent/guardian**
  - Personal information should be **filled out entirely**.



- If the child has ongoing medical concerns, an explanation should be provided (i.e. chronic ear infections, ADHD, etc.)
- If the child is enrolled in the Exceptional Family Member Program (EFMP), an explanation should be provided (i.e. asthma, cystic fibrosis, etc.)

MEDICAL HISTORY					
	YES	NO		YES	NO
1. Any hospitalization or operations			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 consciousness			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. Autism Spectrum Disorder		
13. Chest pain with exercise			26. Other (please list below)		

- Items 1-26 should be marked as “Yes” or “No”. **All items need to be answered** with the exception of #26, unless the answer is “Yes”.
- **All medical conditions** indicated on the medical history **should match** any medical conditions listed on **other relevant forms** (i.e. Screening Tool #1, SDS, MAPs).



- Any questions answered **“Yes”** should include **a brief explanation**.
- All ongoing **medications** that the child is currently taking should be listed (i.e. Concerta, Zyrtec, etc.). **The Name, Dosage and Frequency** are required and should be consistent with current medication prescription labels.
- **All allergies** to include food, medicine and insect bites should be listed. Allergies listed on the health assessment **need to match** those listed on the **Allergy MAP and SDS** if food related. The Type (i.e. peanuts, ant bites, etc.) and Reactions (i.e. hives, rash, difficulty breathing, etc.) should be listed.

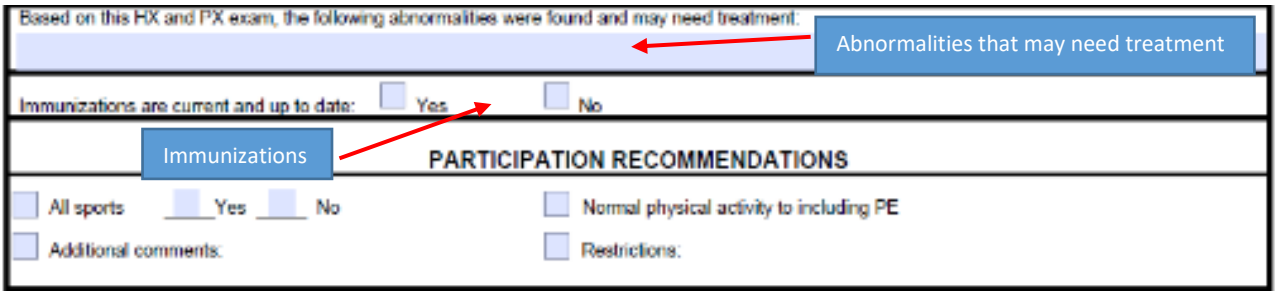
PART B: Physical Exam

Medical Staff Assessment (Completed by licensed independent practitioner: Doctor-Dr., Nurse Practitioner-NP, Physician's Assistant-PA)

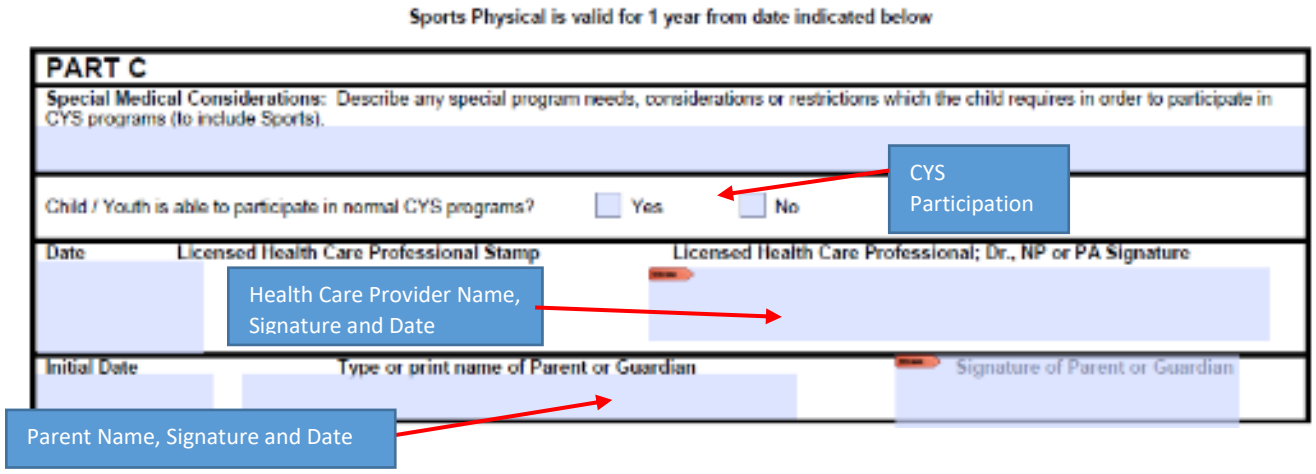
Age YRS MOS	Height cm. (%ile)	Weight kgs. (%ile)
BP: / P:	Visual Acuity Right / Left /	Tested with / without glasses

	NORMAL	ABNORMAL	N / A	COMMENTS
1. Eyes				
2. Ears, Nose & Throat				
3. Hearing				
4. Mouth & Teeth				
5. Neck (Soft tissues)				
6. Cardiovascular				
7. Chest & Lungs				
8. Abdomen				
9. Genitalia – Hernia				
10. Skin & Lymphatics				
11. Spine – Scoliosis				
12. Extremities				
13. Neurological				
14. Wears braces / plates				

- **Part B** must be completed by a **Doctor, Nurse Practitioner or Physician's Assistant**.
  - The child's age, height, weight, blood pressure, pulse and visual acuity should be marked as well as a review of items 1-14.

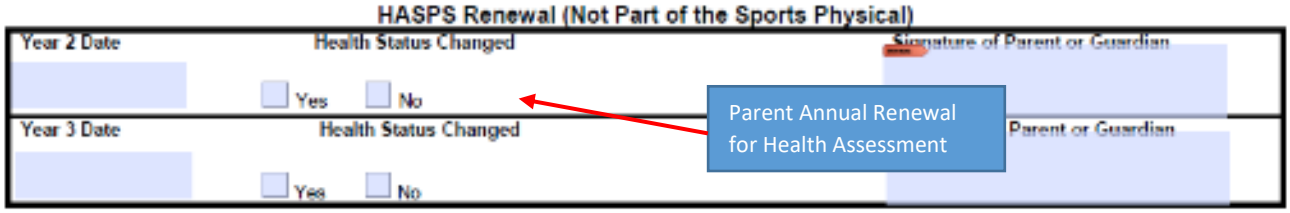


- **Any abnormalities** found during the health assessment should **be indicated** and comments provided for further explanation.
- **The health care provider** must also indicated if **immunizations are current** and up-to-date.
- This form may also be used for sports participation. The health care provider should also indicate participation in CYS sports and general physical activity with or without restrictions if applicable.
- **A sports physical is valid for 12 months** from the date of **health care provider's signature**.



- **Part C** must be completed by a **Doctor, Nurse Practitioner or Physician's Assistant** and **signed by the parent or guardian.**

- This section indicates any further information that addresses special program needs, considerations or restrictions for CYS participation.
- CYS program participation must be indicated either "Yes" or "No".
- Health Care Provider must stamp, sign and date.
- Parent must print name, sign and date.
- **Both signatures** are **required** or the form is not complete.



- The Health Assessment is only **valid for 12 months** from the **date of exam**, but **may be renewed annually** by the parent/guardian **if there are no changes** in the child's health status.
- The **Health Assessment cannot exceed 3 years** from the **date of the exam**.
- A school, state well baby, or other health assessment/sports physical form that possesses similar medical information identified on the Health Assessment/Sports Physical form is acceptable in place of the Health Assessment/Sports Physical form. In this instance, parents must still complete Part A and Part C of the Health Assessment/Sports Physical.