



MIAT Paperwork Quick Tips

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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			
<input type="checkbox"/> Initial Registration	<input type="checkbox"/> Re-registration/already in program	Date in from Patron: _____	
On waiting list? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Current Program	Date out to APHN: _____	
Date care needed? _____	<input type="checkbox"/> Change in Condition		
PART A- GENERAL INFORMATION (Parent completes)			
Child/Youth's Name	Child/Youth School Grade (example: 3rd Grade)	Date of Birth (YYYYMMDD)	Age
Type of Program Requested (check all that apply):			
<input type="checkbox"/> Hourly Care	<input type="checkbox"/> Full Day Care	<input type="checkbox"/> Middle School/Teen Program	<input type="checkbox"/> Summer Camp
<input type="checkbox"/> Part Day Care	<input type="checkbox"/> Before/After School Care	<input type="checkbox"/> SKIES/Instructional Classes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	8. Emotional problems/difficulties?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
a. Does it require a rescue medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	9. Autism Spectrum Disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Allergies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	10. Developmental Disability?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
a. Does it require a rescue medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	11. Visual problems/difficulties not corrected by glasses/contacts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Dietary Restrictions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	12. Hearing problems/difficulties?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> a. Medically-based <input type="checkbox"/> b. Religiously-based			13. Speech/language delays?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	14. Other developmental delays?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Epilepsy/Seizures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	15. Physical disability?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Attention Deficit/Hyperactivity Disorder (ADD/ADHD)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	16. Other medical condition or concerns? If yes, please explain.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
a. Is your child/youth prescribed medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
7. Diagnosed Behavior/Conduct concerns?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
a. Is your child/youth prescribed medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Child/Youth's Name: <input type="text"/>		
PART D - EARLY INTERVENTION AND SPECIAL EDUCATION		
Does your child/youth receive special services/therapies? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify:	Does your child/youth have an.	
 	a. Individualized Education Plan (IEP)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Individualized Family Service Plan (IFSP)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. 504 Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No
PART E - EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) ENROLLMENT		
Is your child enrolled in the EFMP? <input type="checkbox"/> Yes <input type="checkbox"/> 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 (YYYYMMDD)
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 status, please notify us immediately.		

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>

Name of Medical Center
(MAMC, Nisqually Clinic,

Name of Child

JBLM

PART F - RELEASE OF INFORMATION

Is this child/youth currently covered by TRICARE or other military health care? Yes No

I authorize _____ to release any medical information regarding my child
(name of Medical Treatment Facility or physician's practice)

_____ to the _____
(name of child) (name of installation)

Child, Youth & School (CYS) services and Multidisciplinary Inclusion Action Team (MIAT) personnel, are necessary to conduct a MIAT review. This authorization will remain in effect for one year. I understand I may revoke this consent in writing at any time before expiration, but any action taken by the MIAT team on this authorization prior to revocation is valid and will remain in effect.

I understand that information disclosed pursuant to this authorization is For Official Use Only (FOUO) and may be subject to redisclosure. I understand that information redisclosed is no longer protected by DoD 6025, 18-R; however, confidentiality of this information will remain protected by the Privacy Act of 1974, 5 U.S.C. section 552a.

The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.

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

Parent Signature for “Yes” answers

- 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>

Child/Youth's Name: _____		
PART G - ARMY PUBLIC HEALTH NURSE (APHN) CASE REVIEW		
Medical Records Reviewed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Available		
Special Needs/Diagnosis:		
Medical History (Applicable to Special Needs/Diagnosis):		
Training Required for CYS Staff/FCC Provider (detail type of training, who will provide the training and projected timeline):		
Recommendation Summary (if additional space is needed please add a continuation page):		
Documents Reviewed		
REVIEWED (check all that apply):		
<input type="checkbox"/> Allergy MAP <input type="checkbox"/> Diabetes MAP <input type="checkbox"/> Epilepsy/Seizure MAP <input type="checkbox"/> Respiratory MAP <input type="checkbox"/> Special Diet Statement		
MULTIDISCIPLINARY INCLUSION ACTION TEAM REQUIRED:		
<input type="checkbox"/> Administrative <input type="checkbox"/> Modified <input type="checkbox"/> Full <input type="checkbox"/> Annual Review		
APHN Printed Name or Stamp	APHN Signature	Date (YYYYMMDD)
Date Received by APHN (YYYYMMDD)	Date Returned to Parent Central Services/EFMP (YYYYMMDD)	

MIAT Determination

- 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

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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: <input type="checkbox"/> Yes <input type="checkbox"/> No Can Self-Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies:	Symptoms:	Medication (as directed on prescription label): Can Self-Carry: <input type="checkbox"/> Yes <input type="checkbox"/> No Can Self-Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies:	Symptoms:	Medication (as directed on prescription label): Can Self-Carry: <input type="checkbox"/> Yes <input type="checkbox"/> No Can Self-Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> 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-Medicare** indicates if the child can self-carry and self-administer their rescue medication. This section is **only applicable for School Age Children and Youth**.

Name of Parent/Guardian	Parent Name, Signature and Date	Parent/Guardian Signature	Date (YYYYMMDD)
Name of Youth <i>(if applicable)</i>	Youth Name, Signature and Date	Youth Signature <i>(if applicable)</i>	Date (YYYYMMDD)
Stamp of Health Care Provider		Health Care Provider Signature	Date (YYYYMMDD)
Name of Army Public Health Nurse	APHN Name, Signature and Date	Army Public Nurse Signature	Date (YYYYMMDD)

Health Care Provider
Name, Signature and
Date

- 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

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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 <i>(Check all that apply)</i>					
<input type="checkbox"/> Animal Dander	<input type="checkbox"/> Dust	<input type="checkbox"/> Mold	<input type="checkbox"/> Pollen	<input type="checkbox"/> Tobacco Smoke	<input type="checkbox"/> Cold Air
<input type="checkbox"/> Vacuum Cleaning	<input type="checkbox"/> Strong Odors/Sprays	<input type="checkbox"/> Medication	<input type="checkbox"/> Other:		

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

RESPIRATORY SYMPTOMS <i>(Check all that apply)</i>	
<input type="checkbox"/> Excessive dry cough	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Tightness in the chest	<input type="checkbox"/> Wheezing (a whistling sound when the child breathes)
<input type="checkbox"/> Mild chest retraction (<i>child is "pulling in" chest while breathing</i>)	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

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

MEDICATION/TREATMENT PLAN	
Administer the rescue medication	as directed on prescription label.
<i>(name of medication)</i>	
Route:	<input type="checkbox"/> Inhaler <input type="checkbox"/> Inhaler with Spacer <input type="checkbox"/> Nebulizer
Dose:	<input type="checkbox"/> May Repeat <i>one time after</i> <input type="checkbox"/> Do Not Repeat
Can Self-Carry:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can Self-Medicating:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Route of Administration

Name of rescue medication

Child can or cannot self-carry/administer medication

Repeat Dose, "Yes" or "No"

- 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.

Name of Parent/Guardian	Parent Name, Signature and Date	Parent/Guardian Signature	Date (YYYYMMDD)
Name of Youth (if applicable)	Youth Name, Signature and Date	Youth Signature (if applicable)	Date (YYYYMMDD)
Stamp of Health Care Provider	Health Care Provider Name, Signature and Date	Health Care Provider Signature	Date (YYYYMMDD)
Name of Army Public Health Nurse	APHN Name, Signature and Date	Army Public Nurse Signature (This signature serves as the exception to medication policy)	Date (YYYYMMDD)

- 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			
<input type="checkbox"/> Lip Smacking	<input type="checkbox"/> Falling Down	<input type="checkbox"/> Rigidity Stiffness	<input type="checkbox"/> Blue Color to Lips
<input type="checkbox"/> Eye Rolling	<input type="checkbox"/> Shallow Breathing	<input type="checkbox"/> Froth from Mouth	<input type="checkbox"/> Loss of Consciousness
<input type="checkbox"/> Staring	<input type="checkbox"/> Twitching	<input type="checkbox"/> Thrashing/Jerking	<input type="checkbox"/> Other: _____
History of Febrile Seizures (<i>explain</i>)			

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

EPILEPSY/SEIZURE MEDICATIONS	
Medication (<i>as directed on prescription label</i>)	
<div style="border: 1px solid black; background-color: #e0e0e0; padding: 5px; display: inline-block;"> Febrile seizure medication and temp to be given </div>	
Form Febrile Seizures temperature of _____	call Parent for Pick-Up.
Medication for immediate use in case of seizure as directed on prescription label. (<i>May require an exception to policy</i>)	
<div style="border: 1px solid black; background-color: #e0e0e0; padding: 5px; display: inline-block;"> Rescue Med to be given for seizure </div>	

- 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.

I agree with the plan outlined above.			
Name of Parent/Guardian	Parent Name, Signature and Date	Parent/Guardian Signature	Date (YYYYMMDD)
Name of Youth (if applicable)	Youth Name, Signature and Date	Youth Signature (if applicable)	Date (YYYYMMDD)
Stamp of Health Care Provider	Health Care Provider Name, Signature and Date	Health Care Provider Signature	Date (YYYYMMDD)
Name of Army Public Health Nurse	APHN Name, Signature and Date	Army Public Nurse Signature	Date (YYYYMMDD)

- 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

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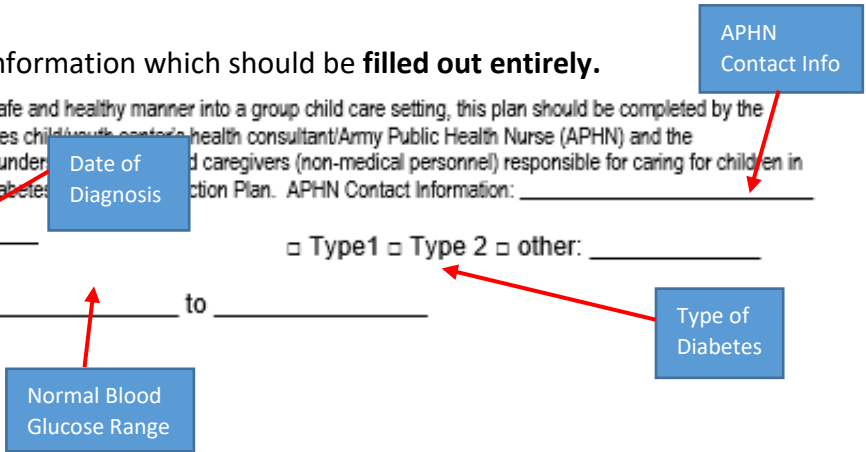
PILOT - CYS SERVICES DIABETES DAILY MEDICAL ACTION PLAN (Form to be completed by Health Care Provider)		
Child/Youth's Name	Date of Birth	Date
Sponsor Name		
Health Care Provider	Health Care Provider Phone	

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

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 caregivers (non-medical personnel) responsible for caring for children in a group setting may be performing the tasks ordered on this Diabetes Daily Medical Action Plan. APHN Contact Information: _____

Date of Diabetes Diagnosis: _____ Type 1 Type 2 other: _____
DAY/MONTH/YEAR

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



Normal Blood Glucose Range

Type of Diabetes

DAILY CARE REQUIREMENTS (required during child care hours)			
<input type="checkbox"/> Food Monitoring	<input type="checkbox"/> Blood Glucose Monitoring	<input type="checkbox"/> Activity Monitoring	<input type="checkbox"/> Insulin Therapy
<input type="checkbox"/> Other: _____			
Storage of Diabetic Supplies and Emergency Response Medications (all supplies and medications supplied by parent/guardian)			
<input type="checkbox"/> Blood Glucose Meter & Test Strips	<input type="checkbox"/> Ketone Meter & Test Strips	<input type="checkbox"/> Lancets	<input type="checkbox"/> Glucagon
<input type="checkbox"/> Insulin Pen	<input type="checkbox"/> 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

- | | |
|--|--|
| <input type="checkbox"/> Meal/Snack Portion Control | <input type="checkbox"/> Verification of accuracy of counting of carbohydrates |
| <input type="checkbox"/> Verification of serving size | <input type="checkbox"/> Verification of carb data entry into insulin pump |
| <input type="checkbox"/> Verification of amount of food consumed | |
| <input type="checkbox"/> Documentation on Food Log | <input type="checkbox"/> 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: | <input type="checkbox"/> Before Meals/Snacks | <input type="checkbox"/> _____ Hours After Meals/Snacks |
| <input type="checkbox"/> Before Activity | <input type="checkbox"/> After Activity | <input type="checkbox"/> 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

- | |
|---|
| <input type="checkbox"/> Yes - Brand/Model of the blood glucose meter: _____ |
| Preferred testing site: <input type="checkbox"/> Fingertips <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh <input type="checkbox"/> Other: _____ |
| <i>Note: If severely low blood glucose (hypoglycemia) is suspected only use the fingertips to check blood glucose.</i> |
| <input type="checkbox"/> No - Child/Youth has a Continuous Glucose Meter (CGM) - Brand/Model: _____ |
| Alarms set for: Low: _____ (mg/dl) High: _____ (mg/dl) |
| <input type="checkbox"/> Take action based on alarms and readings |
| <input type="checkbox"/> Confirm CGM results with a finger stick check before taking action based on CGM blood glucose readings. |
| <i>Note: If child/youth has symptoms or signs of hypoglycemia, check finger stick blood glucose level regardless of CGM readings.</i> |

- 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

- | |
|---|
| <input type="checkbox"/> No - CYSS Caregivers will need to perform and monitor blood glucose/ketone checks |
| <input type="checkbox"/> Yes with assistance , child/youth can perform and self-monitor blood glucose/ketone checks with CYSS staff assistance |
| <input type="checkbox"/> Yes independently , child/youth can independently perform and self-monitor blood glucose/ketone checks and can alert CYSS staff if assistance is required |
| <input type="checkbox"/> 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.

Method of Injection

Site of Injection

Who can Administer Insulin

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.

- This section 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.

INSULIN PUMP:
 Brand/Model: _____ Type of Insulin: _____
 For blood glucose greater than _____ mg/dl for _____ hours call parents/guardian for pickup.

Follow actions and emergency protocols for signs/symptoms of low or high blood glucose (hypoglycemia/hyperglycemia)

Child/Youth can self-manage their insulin pump:

No - Parent/Guardian or authorized adult designee must assist child/youth to manage insulin pump settings.

Yes with assistance, child/youth can self-manage their insulin pump but may need CYSS staff to oversee entering blood sugar and meal information.

Yes independently, child/youth can independently manage their insulin pump without any assistance or supervision.

- 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.

I agree with the plan outlined above.

Printed Name Parent/Guardian	Parent/Guardian Signature	Date (YYYYMMDD)
Printed Name Youth, if applicable	Youth Signature	Date (YYYYMMDD)
Stamp of Health Care Provider	Health Care Provider Signature	Date (YYYYMMDD)
Printed Name Program Director / FCC Provider	Program Director / FCC Director Signature	Date (YYYYMMDD)
Printed Name APHN/Health Consultant	APHN/Health Consultant Signature	Date (YYYYMMDD)

- 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

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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		
<input type="checkbox"/> Shakiness	<input type="checkbox"/> Irritable/Confused	<input type="checkbox"/> Weak
<input type="checkbox"/> Pale or flushed face	<input type="checkbox"/> Looks dazed	<input type="checkbox"/> Hungry
<input type="checkbox"/> Sweaty	<input type="checkbox"/> Headache	<input type="checkbox"/> Dizzy
<input type="checkbox"/> 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: <input type="checkbox"/> 3-4 glucose tablets <input type="checkbox"/> 15 gm glucose gel <input type="checkbox"/> A small cup of regular juice or soda (4 ounces) <input type="checkbox"/> Other: _____ <p style="text-align: center;">Repeat blood glucose level in 15 minutes</p>	
2) If blood glucose is between _____ and _____ and child/youth is able to swallow, repeat food items per step 1. <p style="text-align: center;">Repeat blood glucose level in 15 minutes</p>	
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. <p style="text-align: center;">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!</p>	
EMERGENCY RESPONSE: SEVERELY LOW BLOOD GLUCOSE REQUIRES IMMEDIATE ACTION	Notify Emergency Medical Services and notify parent/guardian. <input type="checkbox"/> 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		
<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Nausea / Stomach ache	<input type="checkbox"/> Heavy breathing
<input type="checkbox"/> Extreme Thirst	<input type="checkbox"/> Warm/dry flushed skin	<input type="checkbox"/> Headache
<input type="checkbox"/> Unable to Concentrate	<input type="checkbox"/> Combative behavior	<input type="checkbox"/> "Feels low"
<input type="checkbox"/> 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 _____: <input type="checkbox"/> Give child/youth _____ cups of water per hour. <input type="checkbox"/> Check <input type="checkbox"/> Urine <input type="checkbox"/> Blood ketones every _____ hour(s). <input type="checkbox"/> Other: _____ <p style="text-align: center;">Repeat blood glucose level in _____ minutes</p>	
If blood glucose is between _____ and _____ give an additional dose of insulin of _____ units. <p style="text-align: center;">Repeat blood glucose level in _____ minutes</p>	
If blood glucose is between _____ and _____ notify parents/guardian for pick-up. <p style="text-align: center;">For signs/symptoms of severely high blood glucose (hyperglycemia): SHORTNESS OF BREATH, VOMITING, BLOOD KETONES OF _____, OTHER: _____ CONDUCT EMERGENCY RESPONSE PROTOCOL</p>	
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.

PILOT - CYS SERVICES DIABETES EMERGENCY MEDICAL ACTION PLAN	
(Form to be completed by Health Care Provider)	
Follow Up	
This Diabetes Emergency Medical Action Plan must be updated/revised whenever medications or child/youth's health status changes. If there are no changes, the Diabetes Emergency Medical Action Plan must be updated at least every 12 months.	
Field Trip Procedures	
<ul style="list-style-type: none">Rescue medications should accompany child during any off-site activities.The child/youth should remain with staff or parent/guardian during the entire field trip: <input type="checkbox"/> Yes <input type="checkbox"/>Staff/providers on trip must be trained regarding rescue medication use and this health care plan.This plan must accompany the child on the field trip.Other: (specify) _____	Location of medication during a fieldtrip
Self-Medication for School Age Youth	
<input type="checkbox"/> YES	Youth can self-medicate. I have instructed _____ in the proper way to use his/her medication. It is my professional opinion that s/he SHOULD be allowed to carry and self-administer his/her medication. Youth has been instructed not to share medications and should youth violate these restrictions, the privilege of self-medicating will be revoked and the youth's parents notified. Youth is required to notify staff when carrying medication
<input type="checkbox"/> NO	It is my professional opinion that _____ SHOULD NOT carry or self-administer his/her medication.
Bus Transportation should be Alerted to Child/Youth's Condition.	
<ul style="list-style-type: none">This child/youth carries rescue medications on the bus. <input type="checkbox"/> Yes <input type="checkbox"/> NoRescue medications can be found in: <input type="checkbox"/> Backpack <input type="checkbox"/> Waist pack <input type="checkbox"/> On Person <input type="checkbox"/> Other: _____Child/youth will sit at the front of the bus. <input type="checkbox"/> Yes <input type="checkbox"/> NoOther: _____	Medication guidance for Bus Transportation

Child can or cannot self-carry/administer medication

- 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.

Parental Permission/Consent
Parent's signature gives permission for child/youth personnel who have been trained in medication administration by the APHN or their designee to administer prescribed medicine and to contact emergency medical services if necessary. I understand that I am responsible for providing all of the medication and other necessary items for my child's/youth's care, to include sharps waste disposal and management. I also understand my child/youth must have required medication with him/her at all times when in attendance at CYS programs. Parent must be readily available via telephone in the event of a diabetic emergency.
Youth Statement of Understanding
I have been instructed on the proper way to use my medication. I understand that I may not share medications and should I violate these restrictions, my privileges may be restricted or revoked, my parents will be notified and further disciplinary action may be taken. I am also required to notify staff when carrying or taking my medication.

I agree with the plan outlined above.

Parent Name, Signature and Date	Printed Name of Parent/Guardian	Parent/Guardian Signature	Date (YYYYMMDD)
	Printed Name of Youth (if applicable)	Youth Signature	Date (YYYYMMDD)
Health Care Provider Name, Signature and Date	Stamp of Health Care Provider	Health Care Provider Signature	Date (YYYYMMDD)
	Printed Name of Army Public Health Nurse	Army Public Health Nurse Signature	Date (YYYYMMDD)
APHN Name, Signature and Date	(This signature serves as the exception to medication policy)		

Form Updated 21 Jul 09

- 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

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

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

CYS Services programs participate in the Child and Adult Care Food Program (CACFP) and must serve meals/snacks meeting the CACFP requirements. Food substitutions may be made only when supported by a medical physician/health care professional. The medical physician must specify, in writing, the food to be omitted from the participant's diet and the food or choice of foods that may be substituted to meet your child/youth's nutritional requirements.

CYS DOES NOT REQUIRE participating programs to provide food substitutions for children based on religious preferences but does allow such variation as appropriate substitutions are made. Army policy allows programs to provide special diet requirements for religious reasons. In order for Army CYS programs to honor parents' special requests, patrons who request food substitutions for religious reasons are required to have a statement from a representative of their religious institution on file.

Please check one:

Participant has a disability or a medical condition and requires a special meal or accommodation (e.g. juvenile diabetes, allergy to peanuts, severe food allergy that results in anaphylaxis). CYS Services programs participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. A licensed Healthcare Provider must sign this form. Licensed health care providers authorized to provide approval are doctors of medicine (MD), osteopathic physicians (DO), certified registered nurse practitioners (NP), or certified physician's assistants (PA). **THIS FORM MUST BE SUBMITTED PRIOR TO ATTENDING CARE. NOTE: Family food preferences are not an appropriate use of this form and cannot be accommodated in CYS Services programs.**

Participant is requesting a special diet due to the Family's religious beliefs. APHN review not required. **THIS FORM MUST BE SUBMITTED WITHIN 30 DAYS OF RECEIPT. SUBSTITUTIONS MUST BE PROVIDED UPON COMPLETION OF THIS FORM.**

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

MEDICAL SPECIAL DIET		
Listed above is the food(s) to be omitted from the diet and the foods that may be substituted. *NOTE: Substitutions will be provided as indicated on page 2 of this form unless otherwise specified. <i>I certify that the above participant requires special accommodations as indicated above.</i>		
Stamp of Health Care Provider	Health Care Provider Signature	Date (YYYYMMDD)
RELIGIOUS SPECIAL DIET		
Listed above is the food(s) to be omitted from the diet and the foods that may be substituted. *NOTE: Substitutions will be provided as indicated on page 2 of this form unless otherwise specified. <i>I certify that the above participant requires special accommodations as indicated above.</i>		
Name of Representative of Religious Institution	Signature of Representative of Religious Institution	Date (YYYYMMDD)

- 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 (<i>cheese, yogurt</i>)
Eggs	Protein	Cheese
Milk (<i>Lactose Intolerant</i>)	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.
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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)
Parent Name, Signature and Date		
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 <i>(if applicable)</i>	Signature of Youth	Date (YYYYMMDD)
Youth Name, Signature and Date		
Name of Army Public Health Nurse	Signature of Army Public Health Nurse <i>(NOTE: APHN review not required for Religious Special Diets.)</i>	Date (YYYYMMDD)
APHN Name, Signature and Date		

- 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 Doe, John	Home Telephone 123-456-7890 Cell Telephone 234-567-8901	Duty/Work Telephone 253-111-1111	
Sponsor Unit / Work Address Depot	Sponsor SSN xxx-xx-xxxx	Spouse's Work Telephone 253-000-0000	
CHILD HEALTH INFORMATION			
Name of Child Doe, Jane	Birth Date 20150214	Sex <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	

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

Does your child have ongoing medical concerns? (If Yes, explain circumstances and current status)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ongoing Medical Concerns
Is your child enrolled in Exceptional Family Member Program? (If Yes, explain)	<input type="checkbox"/> Yes <input type="checkbox"/> No	EFMP Enrollment

- 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.)

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
BP:		Visual Acuity		
P:		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.

Based on this HX and PX exam, the following abnormalities were found and may need treatment:		Abnormalities that may need treatment
Immunizations are current and up to date: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Immunizations	PARTICIPATION RECOMMENDATIONS	
<input type="checkbox"/> All sports <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Normal physical activity to including PE	
<input type="checkbox"/> Additional comments:	<input type="checkbox"/> Restrictions:	

- **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**.

Sports Physical is valid for 1 year from date indicated below

PART C		
Special Medical Considerations: Describe any special program needs, considerations or restrictions which the child requires in order to participate in CYS programs (to include Sports).		
Child / Youth is able to participate in normal CYS programs? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date	Licensed Health Care Professional Stamp	Licensed Health Care Professional; Dr., NP or PA Signature
	Health Care Provider Name, Signature and Date	
Initial Date	Type or print name of Parent or Guardian	Signature of Parent or Guardian
	Parent Name, Signature and Date	

- **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.

HASPS Renewal (Not Part of the Sports Physical)		
Year 2 Date	Health Status Changed	Signature of Parent or Guardian
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Year 3 Date	Health Status Changed	Parent or Guardian
	<input type="checkbox"/> Yes <input type="checkbox"/> No	

- 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.