

## **INSTRUCTIONS FOR CHILD AND YOUTH PROGRAMS (CYP) REGISTRATION FORM**

A separate form shall be completed for each child registered.

The parent shall complete all the information about the family and/or child.

**STATUS BLOCK:** Circle any area(s) that apply to the status of sponsoring parent (ACT - Active Duty, RET - Retired, RES - Reservist, CIV - DoD Civilian, CTR - DoD Contractor, COM CIV - Community Civilian).

After completing the form, parent(s) must sign and date in the SPONSOR AGREEMENT section. This signature and date verifies that all information is correct and validates the agreement to allow transport for medical or other emergencies.

At least annually or when the information is outdated, a new form will be completed, signed, and dated.

A CYP representative (e.g., clerk, director, provider, etc.) will sign and date in SPONSOR AGREEMENT box as witness to the parent's signature and date.

The original Navy CYP Registration Form (CNICCYP 1700/04) shall be kept in the CYP Child Registration Form File. This file shall be maintained in an easily accessible file and shall be taken outside with the day's sign-in sheet during an evacuation drill or in the event of an emergency. A copy shall be maintained in the child administration file shall be maintained at the front desk administrative area in a locked file cabinet or locked file box. **Programs using CYMS are NOT required to maintain a separate copy in the child's administration file; however, all information must be kept current in CYMS.**

### **CHILD DEVELOPMENT HOME PROGRAMS:**

CDH providers shall maintain the original CYP Registration Form for each child in the home. Forms shall be in an easily accessible location for emergency contact or evacuation.

The CDH office shall maintain an alphabetized current copy of each child's Navy CYP Registration Form for each child enrolled.

Forms shall be in an easily accessible location (for the telephone or for evacuation).

### **FOR ALL PROGRAMS:**

Registration forms, with the sign-in sheet, shall be taken outside during an evacuation drill or in the event of an emergency.

A duplicate copy of each child's Navy CYP Registration Form, with local emergency contact numbers/names must be taken on each field trip.





DEPARTMENT OF THE NAVY  
COMMANDER, NAVY INSTALLATIONS COMMAND  
716 SICARD STREET, SE, SUITE 1000  
WASHINGTON NAVY YARD, DC 20374-5140

1700  
Ser N9/62391  
04 May 10

From: Director, Fleet and Family Programs

Subj: NAVY CHILD CARE PRIORITIES FOR PLACEMENT

Ref: (a) OPNAVINST 1700.9E "Navy Child and Youth Programs"

1. Navy child care programs support the mission readiness, family readiness, retention, and morale of the Total Force during peacetime, contingency operations, periods of force structure change, relocation of military units, base realignment and closure, crisis, natural disaster, and other emergency situations. Priorities for placement are necessary to ensure our programs meet these objectives.

2. In addition to the priorities for placement defined by reference (a), all Navy-operated and subsidized child care programs shall give the highest priority to Wounded Warriors, Fallen Warriors, Individual Augmentees, and Ombudsmen (performing official duties). This includes full-time, part-time and hourly care.

3. To be classified as one of these priorities, eligible patrons are responsible for providing validating documentation:

a. Wounded Warriors - verify enrollment in the Safe Harbor Program (or other Service equivalent) as wounded in a combat zone. Additionally, this category shall be charged category 1 parent fees while in treatment period regardless of total family income.

b. Fallen Warriors - verify sponsor deceased in a combat status. Additionally, these family members are grandfathered into eligibility until their child(ren) age out of the child care system.

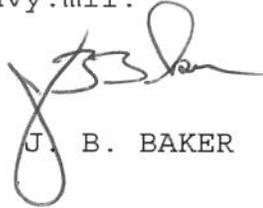
c. Individual Augmentees (IA) - verify official duty orders identifying IA status.

Subj: NAVY CHILD CARE PRIORITIES FOR PLACEMENT

d. Ombudsmen (performing official duties) - Ombudsmen appointment letter from Commanding Officer. Additionally, Ombudsmen shall be provided care free of charge (while performing official duties).

4. In accordance with reference (a), these priorities shall be included in all local standard operating procedures including parent handbooks.

5. The CNIC point of contact is Mr. Greg Young at DSN 288-0519, 202-433-0519 or greg.young@navy.mil.



J. B. BAKER

Distribution:

All Regional/Installation Fleet and Family Readiness Directors  
All Regional/Installation MWR Managers  
All Regional/Installation Fleet and Family Support Managers  
All Regional/Installation Child and Youth Program Managers



# HEALTH INFORMATION

Please PRINT

Participant's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Sponsor's Name: \_\_\_\_\_

**PHYSICAL CONDITIONS:** Please note any conditions, which affect your child and symptoms to help us identify possible problems. Also please list any past (or current) medical problems that your child has had (or has) that we should be aware of: \_\_\_\_\_

**ALLERGIES:**

**Food Allergies:**

Symptoms: \_\_\_\_\_

Action to be taken by YP staff in event of onset: \_\_\_\_\_

**Drug Allergies:**

Symptoms: \_\_\_\_\_

Action to be taken by YP staff in event of onset: \_\_\_\_\_

**Insect, Environmental, or Other Allergies**

Symptoms: \_\_\_\_\_

Action to be taken by YP staff in event of onset: \_\_\_\_\_

Please answer the following (if YES and there are multiple choices please circle the appropriate one):

- YES  NO Does your child have Asthma?
- YES  NO Does your child have Diabetes?
- YES  NO Is your child sun sensitive?
- YES  NO Is your child ADD, ADHD or LD?
- YES  NO Does your child have Seizures, or Shaking Spells?
- YES  NO Does your child have Speech, Hearing or Sight Limitations, tubes in ears?
- YES  NO Does your child suffer from headaches or stomach aches?
- YES  NO Does your child attend a special needs class in school?

\_\_\_\_\_  
(Parent/Legal Guardian Signature)

\_\_\_\_\_  
Date

**PRIVACY ACT STATEMENT:**

AUTHORITY: P.L. 101-89 Sec. 1507 "Military Child Care Act of 1989"; Title 5 U.S.C. 301 Departmental Regulations; E.O. 9397, and OPNAVINST 1700.9D "Child Development Programs."

PURPOSE: To provide Youth Program Services programs with authorization for medical treatment in emergency situations; identify children and sponsors; and record known allergies and special instructions.

ROUTINE USES: Information may be furnished to military or civilian doctors or hospitals in the course of obtaining medical attention for children. The SSN is necessary so that the Youth Programs can identify the individual and his/her records. Information furnished may be disclosed to any DoD component, and upon request, to other governmental agencies in the pursuit of their official duties relating to proper childcare. Finally, the information may be disclosed to law enforcement activities for the purpose of litigation.

VOLUNTARY DISCLOSURE: Furnishing the information is voluntary; however, failure to provide the requested information could result in denial of a child's admission to Youth Programs.

**NAVY CHILD AND YOUTH PROGRAMS  
CHILD AND FAMILY PROFILE  
(SCHOOL-AGE CARE AND YOUTH)**

REQUIRING DIRECTIVE OPNAVINST 1700.9

**PRIVACY ACT STATEMENT**

AUTHORITY: P.L. 101-89, Sec. 1507, "Military Child Care Act of 1989"; Title 5 U.S.C. 301 Department Regulations; E.O. 9397; and OPNAVINST 1700.9 "Child and Youth Programs."

**PURPOSE:** To provide Child and Youth Programs (CYP) with information about enrolled children and their families in order to meet the specific needs of individual children.

**ROUTINE USES** The information is used by CYP Professionals to develop programs specific to individual children and to assist with appropriate placement in classroom and group settings.

**VOLUNTARY DISCLOSURE:** Furnishing the information is voluntary.

**PARTICIPANT DATA**

NAME: (LAST, FIRST, MI)

NICKNAME:

BIRTH DATE:

SCHOOL YOU ATTEND:

**WRITTEN INTERVIEW**

**(To Be Answered By the Participant With Adult Assistance If Necessary)**

What things do you do as a family for fun?

What is your favorite family activity?

What do you do with your friends for fun?

If you could participate in any activity what would it be? (Example: snorkeling, surfing, running a marathon)

What do you enjoy doing when you are alone? (Example: listening to music, reading, video games, surfing the net)

What are your favorite games? (List specific video games, outdoor games, board games, table games, other)

What do you use a computer for? (Example: communicate with a deployed parent, communicate with friends, gaming, surfing)

What sports do you enjoy?

As a spectator, a participant, or both?

Do you presently have the opportunity to participate?

What arts and hobbies do you enjoy? (for example: photography, needlework, painting/drawing, woodworking, music, etc.)

Do you play a musical instrument? If so, what do you play?

What chores are you assigned at home?

What are your favorite subjects at school?

Have you ever been paid for a job outside the home? What was it?

If you could order any piece of equipment for the center what would it be?

What personal accomplishment makes you most proud?

What would you most like to accomplish in your lifetime?

Who is your hero? Who do you most want to be like?

FAMILY INFORMATION			PET INFORMATION	
SIBLINGS	AGE	RELATIONSHIP	TYPE	NAME
<b>EXTENDED FAMILY (LIVING WITH PARTICIPANT OR CLOSE BY)</b>	NAME		RELATIONSHIP	
Anything else you would like us to know about you?				
<b>PARTICIPANT SIGNATURE</b>			<b>DATE</b>	

# NAS-Patuxent River Rassieur Youth Activities Center

46983 Hinkle Circle, Bldg 1597

Patuxent River, MD 20670

1-301-342-1694

## Credit Card Recurring Payment Authorization Form

### Please complete the information below:

I \_\_\_\_\_ authorize NAS-Patuxent River Rassieur Youth Activities Center to  
(full name printed)

charge my credit card indicated below on Monday of each week my child is enrolled in for payment of my Summer Camp bill.

Billing Address \_\_\_\_\_

Phone# \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Email \_\_\_\_\_

Account Type:  Visa       MasterCard       Amex       Discover

Cardholder Name \_\_\_\_\_

Account Number (last four digits only) \_\_\_\_\_

Expiration Date \_\_\_\_\_

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

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