NAVY CHILD AND YOUTH PROGRAM
HEALTH INFORMATION FORM 1700/52

Child's Name (Last, First, Middle):	Sex:	Birthdate (MM/DD/YY):	Age:
Sponsor's Name (Last, First, Middle):			

SPONSOR ACKNOWLEDGEMENTS, PERMISSIONS, AND RELEASES

PART A: IDENTIFICATION OF CHILD/YOUTH MEDICAL AND/OR DIETARY NEEDS

(Some of these questions may require additional documentation. Please refer to the instructions on Page 2.)

1. Does your child have any food allergies? ☐ Yes ☐ No If yes, please list these foods.

2. Does your child suffer from other allergies or allergic reactions (e.g., seasonal hay fever, bee stings, hives, rashes, etc.)? ☐ Yes ☐ No
   If yes, please list the allergies/allergic reactions.

3. Is your child allergic to any medication(s)? ☐ Yes ☐ No If yes, please list the medication(s).

4. If you answered "yes" to any of the above questions, please describe the reaction that your child experiences.

5. Does your child take medication? ☐ Yes ☐ No If yes, please list the medication(s) and how often your child takes the medication.

6. Will your child need to take medication while in care at the CYP? ☐ Yes ☐ No If "yes," please list the medication your child will need to take while in care at the CYP.

7. Does your child require in Epi-pen? ☐ Yes ☐ No If yes, please describe when your child might need an Epi-pen.

8. Does your child have any food intolerances that require food substitutions (e.g., lactose intolerant)? ☐ Yes ☐ No
   If "yes," please describe:

9. Does your child have asthma (Reactive Airway Disease)? ☐ Yes ☐ No

10. Does your child have any medical needs that require assistance while in care? ☐ Yes ☐ No
    If "yes," please check all that apply below.

☐ Blindness/visual problems
☐ Hearing problems
☐ Physical disability
☐ Diabetes
☐ Heart Problems
☐ Epilepsy
☐ Kidney problems
☐ Other chronic medical needs (describe below in #11)

11. If you checked "other chronic medical needs" in #10 above, please briefly describe your child's chronic medical needs.

12. Briefly describe any type of assistance your child will need while in care. If your child will not require any type of assistance while in care, indicate "None."

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PART B: OTHER NEEDS REQUIRING ASSISTANCE WHILE IN CARE

13. Check any of the following needs that your child may need assistance with while in care:

☐ Communication (e.g., speech/language delay) ☐ Behavior (e.g., oppositional defiant disorder) ☐ Learning and attention (e.g., attention-deficit hyperactivity disorder)	☐ Social/emotional (e.g., anxiety disorder) ☐ Developmental (e.g. autism spectrum disorder)

14. If you checked any boxes in #13, briefly describe the type of assistance your child will need while in care.

PART C: EARLY INTERVENTION AND SPECIAL EDUCATION

15. Is your child receiving services through an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP)?
☐ Yes ☐ No

PART D: EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) ENROLLMENT

16. Is your child enrolled in the EFMP? ☐ Yes ☐ No

I acknowledge that all the above information is true and accurate. I understand that I must immediately report any changes in my child's health or other needs to the CYP so that the staff can keep my child safe and healthy and provide the best possible care. Changes to my child's health information may require additional medical documentation and meeting with the Navy CYP Inclusion Action Team (IAT).

SIGN HERE

Sponsor's Signature and Date (Signature indicates the sponsor has provided true and accurate information to the best of his/her knowledge)

SIGN HERE

CYP Professional's Signature and Date (Signature indicates the CYP Professional has reviewed the information provided on this form and will alert the CYP Director immediately to ensure any necessary accommodations are made for the child)

This form must be reviewed by the parent(s) each year during the annual registration process. If there are no changes to be made, the parent(s) may simply initial and date the form. If there are changes to be made, a new form must be completed.

Sponsor's Initials and Date:	*Sponsor's Initials and Date:*	*Sponsor's Initials and Date:*	*Sponsor's Initials and Date:*
_____	_____	_____	_____

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 your child's overall health and needs that may affect his/her care at the CYP.
ROUTINE USES: Information may be furnished to military or civilian doctors or hospitals in the course of obtaining medical attention for children. The information may also be shared with members of the command Inclusion Action Team (IAT) for the purpose of identifying any accommodations your child may need.
VOLUNTARY DISCLOSURE: Furnishing the information is voluntary; however, failure to provide the requested information could result in denial of a child's admission to the CYP.

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INSTRUCTION PAGE

1. Answer "yes" if your child has any food allergies. Please list any food allergies (see definitions at the bottom of the page) which require food substitutions. An Identified Needs Intake package containing a CYP Emergency Action Plan (EAP), (or a current EAP from your child's physician may be used), and a CYP Medical Statement to Request Special Meals and/or Food Substitutions form completed by the child's physician is also required.
2. Answer "yes" if your child has any other allergies or allergic reactions, then list the allergies/allergic reactions. An Identified Needs Intake package containing a CYP Emergency Action Plan (EAP), (or a current EAP from your child's physician may be used) will be required (completed and signed by your child's physician).
3. Answer "yes" if your child is allergic to any medication(s), then list the medications. An Identified Needs Intake package containing a CYP Emergency Action Plan (EAP) (or a current EAP from your child's physician may be used) will be required (completed and signed by your child's physician).
4. If you answered "yes" to Questions 1, 2, or 3, please describe the allergic reactions your child may have if exposed to the allergen.
5. If your child takes any medications, list the medications your child takes and how often he/she takes the medication(s).
6. If your child will require medication while in care at the CYP, answer "yes," then list the medication. If you answer "yes, "an Identified Needs Intake package containing a CYP Emergency Action Plan (EAP), (or a current EAP from your child's physician may be used) and a Medication Administration Form completed by the child's physician is required.
7. Answer "yes" if your child needs an Epi-pen, and if CYP staff will need to use it for the child. Describe the type of situation when an Epi-pen might be needed. If you answer "yes, "an Identified Needs Intake package containing a CYP Emergency Action Plan (EAP), (or a current EAP from your child's physician may be used), and a Medication Administration Form completed by the child's physician is required.
8. Answer "yes" if your child has any food intolerances (see definitions at the bottom of the page) that require food substitutions. If "yes" is entered, provide a short description of the child's food intolerance (e.g., lactose intolerant, gluten intolerant). If you answer "yes," your child's physician must complete a CYP Medical Statement to Request Special Meals and/or Food Substitutions Form before any food substitutions can be made for your child.
9. If your child has asthma (reactive airway disease), answer "yes." If the answer is "yes," an Identified Needs Intake package containing a CYP Emergency Action Plan (EAP) (or a current EAP from your child's physician may be used) and a Medication Administration Form completed by the child's physician is required.
10. If your child has medical needs that require assistance while in care, answer "yes." If the answer is "yes," check all of the boxes that apply. If you answer "yes" to this question, an Identified Needs Intake package containing a CYP Emergency Action Plan (EAP) (or a current EAP from your child's physician may be used) and a Medication Administration Form (if your child will need medication while in care) completed by the child's physician is required.
11. If "Other chronic medical needs" is checked in Question #10, provide a brief description.
12. Provide a short description of any type of assistance your child will need.
13. Check any of the boxes applicable for any other types of assistance your child may need while in care.
14. Provide a brief explanation of any support your child will need while in care to address the areas answered in Question #13 (or indicate "None").
15. Answer "yes" if your child is receiving services through an IFSP or IEP. If the answer is "yes," you should provide a copy of your child's IFSP/IEP so that we can best support his/her needs.
16. Answer "yes" if your child is enrolled in the EFMP. If the answer is "yes," you may wish to provide the EFMP Enrollment Letter for your child's file.

Definitions:

Food Allergy—When a child has a food allergy, his/her body responds to food as if it were a threat. The body's immune system response can be mild or, in rare cases, associated with a severe and life-threatening reaction called anaphylaxis. Allergic reactions are highly unpredictable. The severity of one attack does not predict the severity of the next attack. The only way to prevent a life-threatening reaction is strict avoidance of the allergen.

Food Intolerance—When a child has a food intolerance, it is a reaction of the digestive system and is not dangerous. Although a child may experience gas, bloating, abdominal pain and/or diarrhea, the reactions will pass and the child is not in danger. Children with food intolerances likely do not have prescribed medications for their condition and do not need an EAP. Some common food intolerances are lactose and gluten.