

CHILD AND YOUTH SERVICES HEALTH ASSESSMENT / SPORTS PHYSICAL

DATA REQUIRED BY THE PRIVACY ACT OF 1994			
<p>PRINCIPAL PURPOSE: Information is used by DA personnel to: (1) verify child health status of immunization per admission requirements; (2) note special program considerations or restriction on child participation; (3) execute emergency medical procedure for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program; (5) certify physically fit to participate in sports. ROUTINE USES: No information is disclosed outside DOD. DISCLOSURE: Information is voluntary; however, if information is not provided, individuals may not be able to participate in community activities.</p>			
<p>INSTRUCTIONS: Health Assessment complete sections A & C; Sports Physicals complete sections A, B & C.</p>			
PART A			
Name of Sponsor		Home Telephone	Duty/Work Telephone
		Cell Telephone	
Sponsor Unit / Work Address		Sponsor SSN	Spouse's Work Telephone
CHILD HEALTH INFORMATION			
Name of Child		Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
<p>Does your child have ongoing medical concerns? (If Yes, explain circumstances and current status)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>Is your child enrolled in Exceptional Family Member Program? (If Yes, explain)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
MEDICAL HISTORY			
	YES	NO	YES NO
1. Any hospitalization or operations			
2. Allergies to medicine, insect bites or food			
3. Speech or development delays			
4. Vision Problems (Glasses / Contacts)			
5. Ear or hearing problems			
6. Seizures or Convulsions			
7. Dizziness or fainting with exercise			
8. Headaches			
9. Head injury or loss of consciousness			
10. Neck or back injury			
11. Asthma or difficulty breathing			
12. Heart or blood pressure problems			
13. Chest pain with exercise			
14. Heat stroke or exhaustion			
15. Broken bones or sprains			
16. Joint injuries (Ankle/Knee/Wrist)			
17. Required restricted physical activity			
18. Diabetes			
19. Cancer			
20. Dental or orthodontic braces			
21. Learning problems			
22. Sleep problems			
23. Behavioral problems			
24. ADD / ADHD			
25. Other problems (list below)			
<p>If you answer yes to any of the above, please explain:</p>			
Ongoing Medications			
Name	Dosage		Frequency
Allergies – All Types (Foods, Medicines and Insect Bites)			
Type	Reaction		

PART B: SPORTS PHYSICAL

Medical Staff Assessment (Completed by licensed independent practitioner)

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			

Based on this HX and PX exam, the following abnormalities were found and may need treatment:

Immunizations are current and up to date: Yes No

PARTICIPATION RECOMMENDATIONS

All sports _____ Yes _____ No
 Normal physical activity to including PE
 PA Additional comments:
 Restrictions:

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? Yes No

Date Licensed Health Care Professional Stamp Licensed Health Care Professional Signature

Date Type or print name of Parent or Guardian Signature of Parent or Guardian

Health Assessment Re-Certification

Date Health Status Changed Signature of Parent or Guardian

Yes No

Date Health Status Changed Signature of Parent or Guardian

Yes No