

DEPARTMENT OF THE ARMY CHILD, YOUTH & SCHOOL SERVICES
HEALTH ASSESSMENT FORM (Replaces DA Form 5223-R)
 DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, United States Code, Section 3013
PRINCIPLE PURPOSE(S): Information is used by DA personnel to (1) verify child health and immunization status per admission requirements; (2) note special program considerations or restrictions on child participation; (3) execute emergency medical procedures for chronic illness/conditions.
ROUTINE USE(S): Information provided may be released IAW the Army's blanket routine uses contained in AR 340-21.
DISCLOSURE: Disclosure of requested information is voluntary; however, if information is not provided, individuals may not be able to participate in CYS Services programs.

| | |
|--|--|
| a. CHILD'S NAME (Last, First, MI) | b. PARENT/GUARDIAN NAME (Last, First, MI) |
| c. DATE OF BIRTH (DD, MM, YY) | d. ADDRESS |
| e. NAME OF MEDICAL TREATMENT FACILITY/PHYSICIAN | f. PHYSICIAN ADDRESS |
| g. PHYSICIAN PHONE | |

We need to know about any health concerns relating to your child in order to provide the very best services while your child is at Child, Youth & School Services. The information provided will be shared with the Special Needs Resource Team and the program if needed. Please note that programs are unable to support personal preference diets. Religious based and Doctor prescribed special diet accommodations will be made with written verification. Disclosure of this information is not mandatory, however, services may be denied if information is not given.

NOTE: Children with special needs must be screened by the Special Needs Resource Team prior to enrollment.

PART 1 – To be completed by the parent or guardian

| | YES | NO | COMMENTS IF "YES" |
|--|-----|----|-------------------|
| Is your child enrolled in Exceptional Family Member Program (EFMP)? | | | |
| Is your child under regular supervision of a physician? | | | |
| Is your child fully potty trained? | | | |
| Allergies (Food, Insects, Medication) | | | |
| Asthma or breathing problems | | | |
| Attention Deficit/ Hyperactivity Disorder | | | |
| Autism | | | |
| Behavior or Social Conduct Concerns | | | |
| Bi-Polar or Manic Depressive Disorders | | | |
| Bladder or Bowel Problems | | | |
| Bleeding Disorder | | | |
| Bone, Joint or Muscle Concerns | | | |
| Cancer | | | |
| Cerebral Palsy | | | |
| Cystic Fibrosis | | | |
| Dental Problems | | | |
| Developmental Problems/ Delay | | | |
| Diabetes | | | |
| Head or Spinal injury/problems | | | |
| Hearing Problems or Deafness | | | |
| Heart Problems | | | |
| Hospitalizations | | | |
| Lead Poisoning | | | |
| Seizures | | | |
| Sickle Cell Anemia | | | |
| Skin Problems | | | |
| Special Diet (i.e. Religious Pref./Dr. Prescribed Diet) Programs are unable to support personal preference diets | | | |
| Speech Problems | | | |
| Surgery | | | |
| Vision Problems or Blindness | | | |
| Other Please Specify: | | | |

I give permission for the release of information on this form for confidential use in meeting my child's health and educational needs in the Child, Youth & School Services Programs.

Signature of Parent/Guardian

Date

(To be completed and signed by a licensed health care provider)

| CHILD'S NAME | | DATE OF BIRTH | | DATE PHYSICAL EXAM | | |
|---------------------|-----------|---------------|-----------|--------------------|---------|------|
| IMMUNIZATIONS | DATE | DATE | DATE | DATE | DATE | DATE |
| DTaP/DTP/Td | | | | | | |
| POLIO | | | | | | |
| HIB | | | | | | |
| HEP B | | | | | | |
| MMR | | | | | | |
| VARICELLA | | | | | | |
| PNEUMOCOCCAL (PCV) | | | | | | |
| OTHER | | | | | | |
| MEDICAL EXEMPTION | Permanent | | Temporary | | Reason: | |
| DISEASE HISTORY OF: | | | DATE: | | | |

| HEIGHT: | WEIGHT: | |
|-------------------------------|---------|------------------------|
| PHYSICAL EXAMINATION | NORMAL | IF ABNORMAL - COMMENTS |
| HEAD/EARS/EYES/NOSE/THROAT | | |
| TEETH | | |
| CARDIAC | | |
| RESPIRATORY | | |
| ABDOMEN G1 | | |
| EXTREMITIES/JOINTS/BACK/CHEST | | |
| SKINS/LYMPHNODES | | |
| NEUROLOGIC & DEVELOPMENT | | |

Allergies to food, medication or insect stings (describe, if any):

NONE

Describe health problems or special needs requiring program accommodation or special care:

NONE

I request this child receive the following medication (s) from the Child, Youth & School Services staff.

| Medication | Dose | Frequency | Route | Rx Duration |
|------------|------|-----------|-------|-------------|
| | | | | |
| | | | | |

This child may participate in the following Fort Belvoir instructional & sports programs (check ALL that apply):

- MAY PARTICIPATE WITH NO RESTRICTIONS
- CONTACT/COLLISION (field hockey, football, ice hockey, lacrosse, martial arts, soccer, wrestling)
- LIMITED CONTACT/IMPACT (basketball, cheerleading, gymnastics, skating (ice, inline, roller) skiing, softball, volleyball)
- STRENUOUS NONCONTACT (dance, crew, running/track, swimming, tennis, weightlifting)
- MODERATELY STRENUOUS NONCONTACT (badminton, table tennis)
- NONSTRENUOUS - NONCONTACT (archery, golf)
- NOT CLEARED AND RECOMMENDATIONS: _____

The above named child has been given a routine medial examination and has been found free of infections or contagious disease and is capable of Participating in the Child, Youth & School Services programs with the exceptions listed above.

| | |
|--------------------------------|---------------------------|
| SIGNATURE OF PHYSICIAN OR CPNP | NAME OF PHYSICIAN OR CPNP |
| DATE | ADDRESS |