CHILD, YOUTH, AND SCHOOL SERVICES HEALTH ASSESSMENT/SPORTS PHYSICAL
(AE Reg 608-10-1)

Data required by the Privacy Act of 1974

Authority: 10 USC 3013.

Purpose: (1) Verify child health and status of immunizations for admission requirements; (2) Note special program considerations or restriction on child participation; (3) Execute emergency medical procedures for chronic illness or conditions; (4) Refer the child for enrollment in Exceptional Family Member Program; (5) Certify the child is physically fit to participate in sports.

Routine use: In addition to those disclosures generally permitted under 5 USC 552a(b) of the Privacy Act, these records and information may specifically be disclosed outside DOD as a routine use pursuant to 5 USC 552a(b)(3) as follows: Information from this system may be disclosed to civilian health and welfare departments and agencies in emergency situations. The "Blanket Routine Uses" set forth at the beginning of the Army Compilation of Systems of Records Notices also apply.

Disclosure: Voluntary, but if information is not provided, individuals may not be able to participate in Child, Youth, and School Services activities.

Instructions: For health assessments, complete parts A and C; for sports physicals, complete parts A, B, and C.

Part A

Name of sponsor	Home telephone	Work telephone
	Cell phone	
Sponsor unit/work address		**Spouse's work telephone**

Child Health Information

Name of child	Date of birth (YYYYMMDD)	Sex
		☐ Male ☐ Female

Does your child have ongoing medical concerns? (If yes, explain circumstances and current status.)

☐ No ☐ Yes

Is your child enrolled in the Exceptional Family Member Program? (If yes, explain.)

☐ No ☐ Yes

Medical History

	Yes	No		Yes	No
1. ADD/ADHD	☐	☐	15. Head injury or loss of consciousness	☐	☐
2. Allergies to medicine, insect bites, or food	☐	☐	16. Heart or blood pressure problems	☐	☐
3. Any hospitalization or operation	☐	☐	17. Heat stroke or exhaustion	☐	☐
4. Asthma or difficulty breathing	☐	☐	18. Joint injuries (ankle/knee/wrist)	☐	☐
5. Autism spectrum disorder	☐	☐	19. Learning problems	☐	☐
6. Behavioral problems	☐	☐	20. Neck or back injury	☐	☐
7. Broken bones or sprains	☐	☐	21. Required restricted physical activity	☐	☐
8. Cancer	☐	☐	22. Seizures or convulsions	☐	☐
9. Chest pain with exercise	☐	☐	23. Sleep problems	☐	☐
10. Dental or orthodontic braces	☐	☐	24. Speech or development delays	☐	☐
11. Diabetes	☐	☐	25. Vision problems (glasses/contacts)	☐	☐
12. Dizziness or fainting with exercise	☐	☐	26. Other (list below)	☐	☐
13. Ear or hearing problems	☐	☐			
14. Headaches	☐	☐			

If you answered *yes* to any of the above, please explain:

Ongoing medications

Name	Dosage	Frequency

Allergies - All types (food, medicines, insect bites)

Type	Reaction	Type	Reaction

Part B

Medical Staff Assessment (completed by licensed independent practitioner)

Age		Height			Weight		
Yrs	Mos	in/cm	%		lb/kg	%	
BP /		Visual acuity (tested with/without glasses)					
P		Right /			Left /		

	Normal	Abnormal	N/A	Comments
1. Eyes				
2. Ears, nose, and throat				
3. Hearing				
4. Mouth and teeth				
5. Neck (soft tissues)				
6. Cardiovascular				
7. Chest and lungs				
8. Abdomen				
9. Genitalia - hernia				
10. Skin and lymphatics				
11. Spine - scoliosis				
12. Extremities				
13. Neurological				
14. Wears braces/plates				

Based on this examination, the following abnormalities were found and may need treatment:

Immunizations are current and up to date ☐ Yes ☐ No

Participation recommended

☐ All sports ☐ Yes ☐ No ☐ Normal physical activity including physical education

☐ 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 that could affect the child's participation in Child, Youth, and School Services programs (including sports).

Child/youth is able to participate in normal Child, Youth, and School Services programs: ☐ Yes ☐ No

Licensed healthcare professional stamp	Date	Licensed healthcare professional signature

Type or print name of parent or guardian	Date	Signature of parent or guardian

Health Assessment Annual Recertification

Health status changed	Date	Signature of parent or guardian
☐ Yes ☐ No		

Health status changed	Date	Signature of parent or guardian
☐ Yes ☐ No		