

# CHILD AND YOUTH SERVICES HEALTH ASSESSMENT / SPORTS PHYSICAL

## DATA REQUIRED BY THE PRIVACY ACT OF 1994

**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.

**INSTRUCTIONS:** Health Assessment complete sections A & C; Sports Physicals complete sections A, B & C.

### 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
Does your child have ongoing medical concerns? (If Yes, explain circumstances and current status)		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
Is your child enrolled in Exceptional Family Member Program? (If Yes, explain)		
<input type="checkbox"/> Yes <input type="checkbox"/> No		

### MEDICAL HISTORY

	YES	NO		YES	NO
1. Any hospitalization or operations			14. Heat stroke or exhaustion		
2. Allergies to medicine, insect bites or food			15. Broken bones or sprains		
3. Speech or development delays			16. Joint injuries (Ankle/Knee/Wrist)		
4. Vision Problems (Glasses / Contacts)			17. Required restricted physical activity		
5. Ear or hearing problems			18. Diabetes		
6. Seizures or Convulsions			19. Cancer		
7. Dizziness or fainting with exercise			20. Dental or orthodontic braces		
8. Headaches			21. Learning problems		
9. Head injury or loss of consciousness			22. Sleep problems		
10. Neck or back injury			23. Behavioral problems		
11. Asthma or difficulty breathing			24. ADD / ADHD		
12. Heart or blood pressure problems			25. Other problems (list below)		
13. Chest pain with exercise					

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

#### Ongoing Medications

Name	Dosage	Frequency

#### Allergies – All Types (Foods, Medicines and Insect Bites)

Type	Reaction

<b>PART B: SPORTS PHYSICAL</b>				
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			
	<b>NORMAL</b>	<b>ABNORMAL</b>	<b>N / A</b>	<b>COMMENTS</b>
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: <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>PARTICIPATION RECOMMENDATIONS</b>				
<input type="checkbox"/> All sports                      ____ Yes                      ____ No		<input type="checkbox"/> Normal physical activity to including PE		
<input type="checkbox"/> PA Additional comments:		<input type="checkbox"/> Restrictions:		

**Sports Physical is valid for 1 year from date indicated below**

<b>PART C</b>		
<b>Special Medical Considerations:</b> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Date	Health Status Changed	Signature of Parent or Guardian
	<input type="checkbox"/> Yes <input type="checkbox"/> No	