

**FAMILY CHILD CARE REGISTRATION FORM**

**CYTP MEMBERSHIP DATE:** \_\_\_\_\_

NAME OF CHILD (LAST, FIRST, MIDDLE)		SEX	BIRTHDATE (DD/MM/YY)		AGE
SPONSOR'S NAME (LAST, FIRST, MI)	RANK	BRANCH	UNIT	STATUS: ACT RES CIV RET CTR COMCIV	
HOME ADDRESS (Include City and Zip Code)			HOME PHONE		
EMAIL ADDRESS			CELL PHONE		
DUTY STATION			DUTY PHONE		
(CIRCLE ONE) SINGLE PARENT DUAL MILITARY FULL-TIME WORKING SPOUSE STUDENT SPOUSE PART-TIME WORKING SPOUSE UNEMPLOYED SPOUSE		IF SPOUSE IS MILITARY, PLEASE CIRCLE STATUS: ACT RET ENL OFF		BRANCH	RANK
SPOUSE'S NAME (LAST, FIRST, MI)		PHONE	PLACE OF EMPLOYMENT		

**EMERGENCY NOTIFICATION/RELEASE DESIGNEE (OTHER THAN PARENTS) (MINIMUM OF 2 LOCAL REQUIRED)**

NAME	PHONE NUMBER	RELATIONSHIP
<b>NAME OF PROVIDER</b>	<b>TYPE OF CARE (CIRCLE ONE):</b> FULL TIME PART TIME HOURLY DCC	<b>CONTRACTED DAYS (CIRCLE ALL THAT APPLY):</b> SUNDAY MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY SATURDAY

**CHILD'S CONTRACTED START DATE:** \_\_\_\_\_

**ALLERGIES?** YES NO  
IF YES, WHAT? \_\_\_\_\_

**SPECIAL NEEDS?** YES NO  
IF YES, PLEASE EXPLAIN: \_\_\_\_\_

HAS YOUR CHILD'S CASE BEEN REVIEWED BY THE SPECIAL NEEDS EVALUATION REVIEW TEAM (SNERT)? YES NO  
IS YOUR CHILD ENROLLED IN THE EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP)? YES NO IF YES, WHAT CATEGORY? \_\_\_\_\_

**SPONSOR AGREEMENT**

I HEREBY GIVE MY CONSENT FOR AN AUTHORIZED CHILDREN, YOUTH AND TEEN PROGRAMS REPRESENTATIVE TO CALL AN AMBULANCE FOR MY CHILD, \_\_\_\_\_, ONLY FOR CARE (MEDICAL OR DENTAL) IN AN EMERGENCY SITUATION. I UNDERSTAND THAT A CONSCIOUS EFFORT WILL BE MADE TO NOTIFY ME OR MY EMERGENCY DESIGNESS PRIOR TO SUCH ACTION. ANY EXPENSE INCURRED WILL BE BORNE BY ME AND TREATMENT MAY TAKE PLACE AT ANY MEDICAL FACILITY.

NAME OF CHILD'S MEDICAL INSURANCE COMPANY: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ NAME OF INSURED: \_\_\_\_\_

\_\_\_\_\_  
**SPONSOR SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**CYTP SIGNATURE**

\_\_\_\_\_  
**DATE**

**PRIVACY ACT STATEMENT**

AUTHORITY: P.L. 101-89, Sec 1507, Title 10, United States Code 5013, 5042, 5043  
PURPOSE: To provide Children, Youth and Teen Programs (CYTP) with authorization for medical treatment in emergency situations; Identify children and sponsors; record required immunizations; and record known allergies and special instructions.  
ROUTINE USES: Informaion may be furnished to military or civilian doctors or hospitals in the course of obtaining medical attention for children. Information furnished may be disclosed to any DoD componant, and upon request, to other federal, state and local government agencies in the pursuit of their official duties relating to proper child care.  
VOLUNTARY DISCLOSURE: Furnishing the information is voluntary, however, failure to provide the requested information could result in a denial of a child's admission into the CYTP.

