

Registration Form  
Children, Youth, and Teen Programs  
MCBH Kaneohe Bay, Hawaii

2009

Child's Name \_\_\_\_\_ Gender \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Home Phone # \_\_\_\_\_

Father's Name \_\_\_\_\_ Rank \_\_\_\_\_ Unit \_\_\_\_\_ Branch \_\_\_\_\_

Email address \_\_\_\_\_

Work Phone \_\_\_\_\_ Cellular Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Rank \_\_\_\_\_ Unit \_\_\_\_\_ Branch \_\_\_\_\_

Work Phone \_\_\_\_\_ Cellular Phone \_\_\_\_\_

Email address \_\_\_\_\_

Total Household Members: \_\_\_\_\_

Check boxes that apply:

- My Child has no special needs/allergies/illnesses
- My child has special needs (Please list them below.)

\_\_\_\_\_  
\_\_\_\_\_

- My child has allergies. (Please list below and what action steps must be taken if s/he has an allergy attack.)

\_\_\_\_\_  
\_\_\_\_\_

- My child has an illness. (Please explain below and what precautions must be taken.)

\_\_\_\_\_  
\_\_\_\_\_

**Dual and Single Military ONLY, please circle one:**

Single (unmarried) Active Duty

Dual Active Duty

Current Family Care Plan Date: \_\_\_\_\_

**Single Parent Households must supply the following:**

\*Letter from Command (if Active Duty)

\*Dependency Application

\*Divorce Decree or Legal Separation Court Documents stating that the parent has at least 51% physical custody

Data required by the Privacy Act of 1974

Authority: Title 10, United States Code, 5013,5042,5043

Principle Purpose: To provide information to the Children Youth and Teen Programs personnel on any health problem of an enrolled child and to have necessary information on file to contact authorized adults in case of emergency.

Routine Uses: Information is furnished to attending physicians by CYTP staff when it is necessary for a child to be taken to a medical facility by someone other than parents. Information on immunizations and medical problems will be a part of the CYTP admissions records.

Disclosure: Disclosure of requested information is voluntary; however, if requested information is not provided, children will not be accepted at the Children, Youth and Teen Programs.

Consent Form: I hereby agree and consent that if my child/children exhibit signs of illness or injury and the Children, Youth and Teen Programs is unable to contact me or one of the authorized adults listed that, at the discretion of the Children, Youth and Teen program supervisor on duty, my child may be transported to the Branch Medical Clinic (MCBH), Tripler Army Hospital, and/or Preventive Medicine for medical examination/treatment that is deemed desirable by the personnel of the medical facility.

**Emergency Contact Information:**

I authorize the following people to pick up or drop off my child:

(You must list at least 2 other contacts besides mother/father who live on-island and must be able to reach the site within one (1) hour)

Name	Relationship	Address	Home Phone	Cell Phone

PARENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PARENTS REVISED: \_\_\_\_\_ DATE: \_\_\_\_\_

PARENTS REVISED: \_\_\_\_\_ DATE: \_\_\_\_\_

PARENTS REVISED: \_\_\_\_\_ DATE: \_\_\_\_\_