

INSTRUCTIONS FOR CHILD AND YOUTH PROGRAMS (CYP) REGISTRATION FORM

A separate form shall be completed for each child registered.

The parent shall complete all the information about the family and/or child.

STATUS BLOCK: Circle any area(s) that apply to the status of sponsoring parent (ACT - Active Duty, RET - Retired, RES - Reservist, CIV - DoD Civilian, CTR - DoD Contractor, COM CIV - Community Civilian).

After completing the form, parent(s) must sign and date in the SPONSOR AGREEMENT section. This signature and date verifies that all information is correct and validates the agreement to allow transport for medical or other emergencies.

At least annually or when the information is outdated, a new form will be completed, signed, and dated.

A CYP representative (e.g., clerk, director, provider, etc.) will sign and date in SPONSOR AGREEMENT box as witness to the parent's signature and date.

The original Navy CYP Registration Form (CNICCYP 1700/04) shall be maintained in the child's administrative file. The child administration file shall be maintained at the front desk administrative area in a locked file cabinet or locked file box. A copy shall be kept in the CYP Child Registration Form File. This file shall be maintained in an easily accessible file and shall be taken outside with the day's sign-in sheet during an evacuation drill or in the event of an emergency.

CHILD DEVELOPMENT HOME PROGRAMS:

CDH providers shall maintain the original CYP Registration Form for each child in the home. Forms shall be in an easily accessible location for emergency contact or evacuation.

The CDH office shall maintain an alphabetized current copy of each child's Navy CYP Registration Form for each child enrolled.

Forms shall be in an easily accessible location (for the telephone or for evacuation).

FOR ALL PROGRAMS:

Registration forms, with the sign-in sheet, shall be taken outside during an evacuation drill or in the event of an emergency.

A duplicate copy of each child's Navy CYP Registration Form, with local emergency contact numbers/names must be taken on each field trip.

NAVY CHILD AND YOUTH PROGRAMS REGISTRATION FORM

REQUIRING DIRECTIVE OPNAVINST 1700.9

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

EMERGENCY NOTIFICATION/RELEASE DESIGNEE (other than parents) (minimum of TWO (2) LOCAL REQUIRED)

NAME	PHONE NUMBER	RELATIONSHIP

PROGRAM ENROLLED: CDC CDH BEFORE SCHOOL AFTER SCHOOL VACATION CAMP TEENS
 YOUTH SPORTS OPEN REC KINDERGARTEN CARE INSTRUCTIONAL CLASSES

SCHOOL NAME: _____ GRADE: _____

DATE OF LAST MEDICAL EXAM: _____ STATUS GOOD HEALTH IF NOT, PLEASE SPECIFY:

ALLERGIES: YES NO

IF YES, WHAT?

SPECIAL NEEDS: YES NO

IF YES, EXPLAIN:

HAS YOUR CHILD'S CASE BEEN REVIEWED BY THE SPECIAL NEEDS REVIEW BOARD: YES NO

DOES YOUR CHILD HAVE AN EXCEPTIONAL FAMILY MEMBER CLASSIFICATION: YES NO

IF YES, WHAT IS THE CLASSIFICATION:

SPONSOR AGREEMENT:

I HEREBY GIVE MY CONSENT FOR AN AUTHORIZED CHILD AND YOUTH PROGRAM (CYP) REPRESENTATIVE TO CALL AN AMBULANCE FOR MY CHILD, _____, ONLY FOR CARE (MEDICAL OR DENTAL) IN AN EMERGENCY SITUATION. I UNDERSTAND THAT A CONSCIENTIOUS EFFORT WILL BE MADE TO NOTIFY ME OR MY EMERGENCY DESIGNEES 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 CYP REPRESENTATIVE SIGNATURE DATE

PRIVACY ACT STATEMENT:

AUTHORITY: P.L. 101-89, Sec. 1507, "Military Child Care Act of 1989"; Title 5 U.S.C. 301 Department Regulations; E.O. 9397; and OPNAVINST 1700.9 "Child and Youth Programs."
PURPOSE: To provide Child and Youth Programs (CYP) with authorization for medical treatment in emergency situations; identify children and sponsors; record required immunizations; and record known allergies and special instructions.
ROUTINE USES: Information may be furnished to military or civilian doctors or hospitals in the course of obtaining medical attention for children. The SSN is necessary so that the Child and Youth Programs can identify the individual and his/her records. Information furnished may be disclosed to any DoD component, and upon request, to other federal, state and local governmental agencies in the pursuit of their official duties relating to proper child care. Finally, the information may be disclosed to law enforcement activities for the purpose of litigation.
VOLUNTARY DISCLOSURE: Furnishing the information is voluntary; however, failure to provide the requested information could result in denial of a child's admission to the CYP.



HEALTH INFORMATION

Please PRINT

Participant's Name: _____ Age: _____

Sponsor's Name: _____

PHYSICAL CONDITIONS: Please note any conditions, which affect your child and symptoms to help us identify possible problems. Also please list any past (or current) medical problems that your child has had (or has) that we should be aware of: _____

ALLERGIES:

Food Allergies:

Symptoms: _____

Action to be taken by YP staff in event of onset: _____

Drug Allergies:

Symptoms: _____

Action to be taken by YP staff in event of onset: _____

Insect, Environmental, or Other Allergies

Symptoms: _____

Action to be taken by YP staff in event of onset: _____

Please answer the following (if YES and there are multiple choices please circle the appropriate one):

- YES Does your child have Asthma?
- YES NO Does your child have Diabetes?
- YES NO Is your child sun sensitive?
- YES NO Is your child ADD, ADHD or LD?
- YES NO Does your child have Seizures, or Shaking Spells?
- YES NO Does your child have Speech, Hearing or Sight Limitations, tubes in ears?
- YES NO Does your child suffer from headaches or stomach aches?
- YES NO Does your child attend a special needs class in school?

(Parent/Legal Guardian Signature)

Date

PRIVACY ACT STATEMENT:

AUTHORITY: P.L. 101-89 Sec. 1507 "Military Child Care Act of 1989"; Title 5 U.S.C. 301 Departmental Regulations; E.O. 9397, and OPNAVINST 1700.9D "Child Development Programs."

PURPOSE: To provide Youth Program Services programs with authorization for medical treatment in emergency situations; identify children and sponsors; and record known allergies and special instructions.

ROUTINE USES: Information may be furnished to military or civilian doctors or hospitals in the course of obtaining medical attention for children. The SSN is necessary so that the Youth Programs can identify the individual and his/her records. Information furnished may be disclosed to any DoD component, and upon request, to other governmental agencies in the pursuit of their official duties relating to proper childcare. Finally, the information may be disclosed to law enforcement activities for the purpose of litigation.

VOLUNTARY DISCLOSURE: Furnishing the information is voluntary; however, failure to provide the requested information could result in denial of a child's admission to Youth Programs.



CHILD INFORMATION FORM

Parents,

In an effort to ease your child's transition into the School Age Care Program, we would like to get to know your child better. Please take a few minutes to complete this form with your child.

Child's Name: _____ D.O.B. _____ Age _____

Nickname: _____ How many children are in your family? _____

Has your child previously attended any other School Age Care Program or Day Care program? YES _____ NO _____

If yes, what was the name of the program? _____

What languages are spoken at home? _____

What is your child's favorite game or sport? _____

How do you discipline your child at home? _____

How would you describe your child's temperament? _____

Can your child swim? YES _____ NO _____

Does your child have a fear of the water? YES _____ NO _____

What other information would you like to share about your child?

Parent/Guardian's Signature

Date

NAS-Patuxent River Rassieur Youth Activities Center

46983 Hinkle Circle, Bldg 1597
Patuxent River, MD 20670
1-301-342-1694

Credit Card Recurring Payment Authorization Form

Please complete the information below:

I _____ authorize NAS-Patuxent River Youth Activities Center to charge
(full name printed)
my credit card indicated below on the 1st and 15th of each month for payment of my

(Type of bill: Before, After, B & A)

Billing Address _____

Phone# _____

City, State, Zip _____

Email _____

Account Type: Visa MasterCard Amex Discover

Cardholder Name _____

Account Number (last four digits only) _____

Expiration Date _____

SIGNATURE _____

DATE _____

I authorize the above named merchant to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

**FREE AND REDUCED-PRICE MEAL BENEFIT APPLICATION
CHILD CARE CENTERS: July 1, 2012 – June 30, 2013**

Complete this form so that we may receive reimbursement for meals served to children in our program. For help call _____.

PART 1 – ENROLLED CHILDREN INFORMATION			PART 2 - CASE NUMBER
Last Name	First Name	Check (✓) if foster child If <u>all</u> listed children are foster children, skip to Part 5.	If applicable, give a Food Supplement Program or Temporary Cash Assistance case number for <u>any</u> member of the household.
1.			If completed, skip to Part 5. Last four digits of Social Security Number are <u>not</u> needed.
2.			
3.			
4.			

PART 3 - IF ANY CHILD YOU ARE APPLYING FOR IS HOMELESS, MIGRANT, OR A RUNAWAY, CHECK THE APPROPRIATE BOX AND COMPLETE THE APPLICATION HOMELESS MIGRANT RUNAWAY

PART 4 - HOUSEHOLD MEMBERS AND GROSS INCOME. You must tell us how much and how often.

LIST NAMES OF ALL HOUSEHOLD MEMBERS Include the children named above.	EARNINGS FROM WORK (before deductions)		ADDITIONAL INCOME Child Support, Alimony, TCA, Pensions, Retirement, Social Security, SSI, VA Benefits		ALL OTHER INCOME		Check if NO income
	Income	How Often	Income	How Often	Income	How Often	
1.	\$.		\$.		\$.		<input type="checkbox"/>
2.	\$.		\$.		\$.		<input type="checkbox"/>
3.	\$.		\$.		\$.		<input type="checkbox"/>
4.	\$.		\$.		\$.		<input type="checkbox"/>
5.	\$.		\$.		\$.		<input type="checkbox"/>
6.	\$.		\$.		\$.		<input type="checkbox"/>

PART 5 - SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN)

An adult household member must sign the application. **If Part 4 is completed, the adult signing the form must list the last four digits of his/her Social Security Number, or mark the "I do not have a Social Security Number" box.** (See Privacy Act Statement)

I certify (promise) that all information on this application is true and that all income is reported. I understand that the center will receive Federal funds based on the information I give. I understand that center officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted.

Sign here: _____ Print name: _____ Date: _____
 Address: _____ Phone Number: _____
 City: _____ State: _____ Zip Code: _____ Social Security Number: **XXX-XX- _____** I do not have a SSN

PART 6 - CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)

Choose one ethnicity:	Choose one or more (regardless of ethnicity):		
<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Not Hispanic/Latino	<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian or other Pacific Islander	

PART 7 - SHARING INFORMATION WITH OTHER PROGRAMS

Information that you provide will be used to determine your children's eligibility for free or reduced-price meals. The eligibility status of your children may also be used for other authorized purposes..

Your family may be eligible to receive benefits under the Food Supplement Program (FSP) or the Women, Infants, and Children (WIC) Program. To share your information with these programs, **we must have your permission.** Your decision will not change whether your children get free or reduced price meals. **If you want information shared with FSP or WIC check the "Yes," box.**

You may be contacted about submitting an application for the FSP or WIC if you select **Yes**:
 ___ **Yes, I want** information shared from the Free and Reduced-Price Meal Benefit Application with FSP.
 ___ **Yes, I want** information shared from the Free and Reduced-Price Meal Benefit Application with WIC.

Children eligible for free or reduced-price school meals may also be able to get free or low-cost health insurance through Medicaid or the MD Children's Health Insurance Program (MCHIP). The law allows us to inform Medicaid and MCHIP that your children are eligible for free or reduced price meals, **unless you say no.** Your decision will not change whether your children receive free or reduced-price meals. **If you do not want information shared with Medicaid or the MCHIP, check the "No," box.**

If you do not want information shared with Medicaid or MCHIP, check the "No," box:
 ___ **No, I DO NOT** want information from my Free and Reduced-Price Meal Benefit Application shared with Medicaid or MCHIP.

DO NOT FILL OUT THIS PART. THIS IS FOR CENTER USE ONLY.

Annual Income Conversion: Weekly x 52 Every 2 Weeks x 26 Twice A Month x 24 Monthly x 12

Total Income: \$ _____ Per: Week, Every 2 Weeks, Twice A Month, Month, Year Household size: _____

Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free ___ Reduced ___ Denied ___ Reason: _____

Temporary: Free ___ Reduced ___ Time Period: _____ (expires after ___ days)

Determining Official's Signature: _____ Date: _____

Child Youth Program
Patuxent River, Maryland

Dear Parent/Guardian:

Children need healthy meals to learn. The Child Youth Program offers healthy meals every day. Although all children receive the meals at no charge, the U.S. Department of Agriculture (USDA) will provide Child and Adult Care Food Program (CACFP) funds that support our nutrition program based on your child's eligibility. This letter is a request for you to complete the information on the enclosed Free and Reduced-Price Meal Benefit Application to assist our agency's food service program.

1. **DO I NEED TO FILL OUT AN APPLICATION FOR EACH CHILD?** No. Complete one Free and Reduced-Price Meal Benefit Application for all children in your household enrolled in the same center. We cannot approve an application that is not complete. Fill out all required information. Return the completed application to: Child Youth Program
2. **ADDITIONAL FEDERAL FUNDS ARE AVAILABLE TO OUR AGENCY FOR MEALS SERVED TO CHILDREN IN THE FOLLOWING HOUSEHOLDS:**
 - Households receiving benefits from the Food Supplement Program (FSP) or Temporary Cash Assistance (TCA).
 - Foster children.
 - Households with a gross income within the free limits or reduced limits on the Federal Income Eligibility Guidelines (See Instructions for Applying).
 - Children certified as homeless, runaway or migrant.
 - Some households participating in WIC.
3. **I COMPLETED AN APPLICATION LAST YEAR. DO I NEED TO FILL OUT ANOTHER ONE?** Yes. Your child's application is only good for one year. You must send in a new application each year.
4. **WILL THE INFORMATION I GIVE BE CHECKED?** Yes, your information may be checked.
5. **MAY I APPLY IF SOMEONE IN MY HOUSEHOLD IS NOT A U.S. CITIZEN?** Yes. You or your child(ren) do not have to be U.S. citizens to qualify.
6. **WHO SHOULD I INCLUDE AS MEMBERS OF MY HOUSEHOLD?** Your household includes all those living as one economic unit, related or not (such as grandparents, other relatives, foster children or friends).
7. **WHAT IF MY INCOME IS NOT ALWAYS THE SAME?** List the amount that you normally receive. For example, if you normally make \$1000 each month, but you missed some work last month and only made \$900, put down that you made \$1000 per month. If you normally get overtime, include it, but do not include it if you only work overtime sometimes.
8. **WE ARE IN THE MILITARY. DO WE INCLUDE OUR HOUSING ALLOWANCE AS INCOME?** If you get an off-base housing allowance, it must be included as income. However, if your housing is part of the Military Housing Privatization Initiative, do not include your housing allowance as income.
9. **MY SPOUSE IS DEPLOYED TO A COMBAT ZONE. IS THEIR COMBAT PAY COUNTED AS INCOME?** No, if the combat pay is received in addition to basic pay because of deployment, and it wasn't received before being deployed, the combat pay is not counted as income.
10. **MY FAMILY NEEDS MORE HELP. ARE THERE OTHER PROGRAMS WE MIGHT APPLY FOR?** For information and referral for the Food Supplement Program, Temporary Cash Assistance, and medical programs call 1-800-332-6347.

If you have other questions or need help, call **(301) 342-3902**.

Sincerely,

Terry P. Davis

INTERNET SAFETY RULES

Middle School ■ High School

1

I WILL THINK BEFORE I POST.

I agree not to post information and images that could put me at risk, embarrass me, or damage my future, such as

- » cell & home phone numbers
- » home address
- » sexual messages
- » inappropriate pictures and videos

2

I WILL RESPECT OTHER PEOPLE ONLINE.

I will not

- » post anything rude, offensive, or threatening
- » send or forward images and information that might embarrass, hurt, or harass someone
- » take anyone's personal information and use it to damage his or her reputation

3

I WILL BE CAREFUL WHEN MEETING ONLINE FRIENDS IN PERSON.

I agree to

- » ask my parent or guardian's permission
- » have a parent or guardian accompany me
- » meet in a public place

4

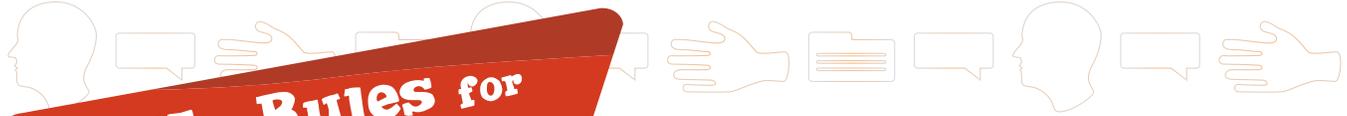
I WILL PROTECT MYSELF ONLINE.

If someone makes me feel uncomfortable or if someone is rude or offensive, I will

- » not respond
- » save the evidence
- » tell my parent, guardian, or another trusted adult
- » report to the website, cell phone company, cybertipline.com, or the police

SIGNED _____

SIGNED _____



My Rules for

Internet Safety

Primary

The Internet is where I learn and play
But I have to be careful everyday
So I pledge to be safer online
And follow these rules all of the time:



1

I will tell my trusted adult if anything makes me feel sad, scared, or confused.

2

I will ask my trusted adult before sharing information like my name, address, and phone number.

3

I won't meet face-to-face with anyone from the Internet.

4

I will always use good netiquette and not be rude or mean online.



signed

signed



My Rules for

Internet Safety

Intermediate

I will use the Internet responsibly. That means making smart decisions about what I look at, who I talk to, and what I say. I pledge to be safer online by following these rules:



1 I will tell my trusted adult if anything makes me feel sad, scared, or confused.

2 I will ask my trusted adult before sharing information like my name, address, and phone number.

3 I won't meet face-to-face with anyone from the Internet.

4 I will always use good netiquette and not be rude or mean online.



signed

signed

Passport to Manhood

For many adolescent males the transition from boyhood to pre-teen to teen to manhood is a challenging one. This journey requires boys and young men to understand and manage such things as physical change in their bodies, relationship with authority, friends and members of the opposite sex, greater freedom and responsibility for personal decisions and increased peer pressure. To help make this transition a positive and healthy one, Boys and Girls Club of Patuxent River is implementing the Passport to Manhood program.

Designed for young boys and pre-teens ages 7-12, passport to pre-teen to manhood addresses such issues as ethics, decision making, wellness, employment and careers, cooperation and conflict, diversity, relationships and self-esteem. The 14 sessions small group program will use role playing, peer discussions, games and art projects to explore values attitudes and behaviors necessary for a healthy transition through adolescent into the teens.

If this is something that you think your son would be interested in, please fill out this form. The meeting will begin with SAC (School Age Care) and sessions will be held in the mornings and afternoons on designated days. Without this permission slip they will be unable to participate.

Child's Name

Age

Parent of Legal Guardian's Signature

Date

Smart Girls
Parent/Guardian consent form

Your daughter has expressed an interest in participating in the Boys & Girls Club of Pax River S.M.A.R.T Girls program.

S.M.A.R.T Girls is a program of prevention that educates girls about healthy attitudes and lifestyles. The program is designed for girls 7-12 and 14-18 years of age. Depending on the age of your daughter, the program may address the following issues:

- 1) Physical and emotional growth
- 2) Media influence and body image
- 3) Eating disorders
- 4) Sexual myths and sexual truths
- 5) Personal values and social interactions
- 6) Female victimization
- 7) Dating responsibility
- 8) HIV and other sexually transmitted diseases
- 9) The importance of regular exams
- 10) Exercise and physical activity
- 11) Culture and food
- 12) Healthy appetites
- 13) Food programs
- 14) Health care connections

In addition, as part of the S.M.A.R.T Girls program, we will be administering a pre and post teen test to assess the girls' knowledge and understanding of these topics.

I DO give permission for my daughter to participate in the S.M.A.R.T Girls program.

I DO NOT give permission for my daughter to participate in the S.M.A.R.T Girls program.

NOTE: It is vital that your daughter return this letter prior to participation in the program.

Child's Name

Age

Parent of Legal Guardian's Signature

Date