USMC Children, Youth & Teen Programs (CYTP) Health Assessment

Privacy Act Statement

AUTHORITY: 10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. 5041, Headquarters, Marine Corps; DoD Instruction 6060.02, Child Development Programs; DoD Instruction 6060.4, Youth Programs; OPNAVINST 1700.9 series; Marine Corps Order 1710.30, Marine Corps Child and Youth Programs (CYP); and SORN NM01764-3

PURPOSE: The information collected on this form is used by Children, Youth and Teen Programs (CYTP) and Inclusion Action Team personnel to determine the general health status of patrons participating in CYTP activities and if necessary the appropriate accommodations for the patron for full enjoyment of CYTP services.

ROUTINE USES: Any release of information contained in this system of records outside of DoD will be compatible with the purposes for which the information is collected and maintained. The DoD Blanket Routine uses may apply to this system of records.

DISCLOSURE: Information is voluntary; however, failure to provide information may adversely impact individuals from participation in CYTP activities.

The public reporting burden for this collection of information, OMB No. 0703-0008, is estimated to average 1.17 hours (70 minutes) per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any burden reduction suggestions to the Department of Defense, Washington Headquarters Services, at wshs.mc-alex.eds.mbx.dd-dod-information-collections@mail.mil. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR RESPONSE TO THE ABOVE ADDRESS.

Responses should be sent to your Regional Director.

<table>
<thead>
<tr>
<th>SPONSOR INFORMATION (please print)</th>
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<tbody>
<tr>
<td>1. Name of Sponsor</td>
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<td>4. Cell Phone</td>
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<tr>
<th>CHILD/YOUTH INFORMATION (please print)</th>
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<tr>
<td>9. Enrolled in Public School ☐ Yes ☐ No</td>
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<tr>
<th>CHILD'S/YOUTH'S MEDICAL HISTORY (Check all that apply)</th>
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<tr>
<td>10. Any hospitalization or operations</td>
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<td>11. Allergies to medicine, insect bites, latex or food (please explain reactions)</td>
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<td>13. Eye or vision Problems (Glasses/Contacts)</td>
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<td>14. Ear or hearing problems</td>
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<td>15. Seizures or Convulsions</td>
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<td>16. Dizziness or fainting with exercise</td>
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<td>17. Headaches</td>
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<td>18. Head injury or loss of consciousness</td>
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<td>19. Neck or back injury</td>
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<td>20. Asthma or difficulty breathing</td>
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<td>21. Heart or blood pressure problems</td>
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<td>22. Chest pain with exercise</td>
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36. If any apply, please explain

37. Is the child/youth enrolled in Exceptional Family Member Program? ☐ Yes ☐ No

38. In what branch of Service

39. Does the child/youth have ongoing medical concerns or special needs/considerations that have required the care of a Healthcare Provider within the last year? (If Yes, explain circumstances and current status) ☐ Yes ☐ No

If there are special considerations, a Health Screening Tool for Inclusion Action Team (page 3) must be completed by the Healthcare Provider.

NAVMC 1750/4 (Rev. 11-2017) (EF)

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### PHYSICAL EXAMINATION

<table>
<thead>
<tr>
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<th>Normal</th>
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<td>58. Based on this examination, the following abnormalities were found</td>
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<td>59. Immunizations are current and up to date</td>
<td>Yes</td>
<td>No (if no, please explain) A copy of the child/youth immunization must be given to CYTP.</td>
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60. Child/Youth is able to participate in normal CYTP programs? Yes No (if no, please explain)

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<td>61. Date</td>
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<td>62. Parent or Guardian Signature</td>
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<td>63. Date</td>
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<td>64. Healthcare Provider Signature</td>
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<td>66. Healthcare Provider Signature</td>
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<tr>
<td>67. Healthcare Provider Stamp or Printed Name &amp; Address</td>
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### Identification of Child/Youth Special Need(s)

68. What special need(s) does the child/youth have?
- Asthma/Reactive Airway Disease
- Allergies (other than seasonal/allergic rhinitis)
- Developmental (e.g. Autism/PDD/Delays)
- Behavioral
- Neurological
- Other (explain)

69. Brief summary of the child's/youth's needs

### Medication

70. Child is on medications related to special needs?  
   - No  
   - Yes (list medications below and indicate which require administration during child care hours)

71. For medically diagnosed allergies, is Epinephrine required?  
   - No  
   - Yes

72. For other diagnoses, are any emergency medications required (e.g. Glucagon, Diastat, Albuterol)?  
   - No  
   - Yes

### CURRENT MEDICATIONS INCLUDING EMERGENCY

73. Name

74. Dosage

75. Frequency

76. During Child Care

77. Assistance with activities of daily living?  
   - No  
   - Yes (explain)

78. Medical Dietary modifications?  
   - No  
   - Yes (explain)

79. Environmental adaptations (e.g. room temperature, wheelchair access)?  
   - No  
   - Yes (explain)

80. Other conditions/adaptations/modifications/recommendations/concerns or comments to ensure the child's/youth's needs are met?  
   - No  
   - Yes (specify and explain)

### Healthcare Provider or Specialist Signature

81. Healthcare Provider or Specialist Signature

82. Date

83. Provider/Specialist Stamp or Printed Name & Address

### Carry and Self-Administer Authorization

84. Phone

85. E-mail

86. Carry and Self-Administer Authorization (to be initiated by the healthcare provider)

87. Child has an Individualized Family Service Plan (IFSP), Individualized Education Plan (IEP), 504 plan or Behavioral Plan?  
   - No  
   - Yes

88. If yes, does he/she have an aide, skills trainer, or additional assistance?  
   - No  
   - Yes

89. For Special Ed/Early Intervention, is the child currently seeing a therapist?  
   - No  
   - Yes

### Early Intervention and Special Education

I understand that all reasonable efforts will be made to accommodate all properly documented special needs as based on IAT determinations. Parent(s)/guardian(s) will be notified if changes or limitations to the plan are necessary. The child's needs may change, and the plan will be reviewed and updated at least annually. Although there is a legal requirement for a Child's Plan, I understand that this form must be updated annually or earlier, if there is a change in condition or need.

90. Parent/Guardian Signature

91. Date

92. Signature

93. Date

94. IAT Meeting date if required

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GENERAL.
The NAVMC 1750/4 is completed by the parent/legal guardian or custodian, or Agent acting pursuant to a power of attorney; and the Healthcare Provider of the Children, Youth and Teen Programs (CYTP) participant. The information provided is used by USMC personnel to: (1) verify child required immunizations per admission requirements; (2) be used by the Inclusion Action Team (IAT) to determine necessary and appropriate accommodations in CYTP activities; (3) execute emergency medical procedure for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program; and (5) determine if at time of enrollment child is physically fit to participate in USMC CYTP programs.

SPONSOR INFORMATION (To be completed by the parent/legal guardian or custodian, or Agent acting pursuant to a power of attorney)
Item 1. Self-explanatory.
Item 2. Self-explanatory.
Item 3. Name of sponsor military organization, otherwise N/A.
Item 4. Self-explanatory.
Item 5. Self-explanatory.

CHILD/YOUTH INFORMATION (To be completed by the parent/legal guardian or custodian, or Agent acting pursuant to a power of attorney)
Item 6. Name of CYTP Participant.
Item 7. Self-explanatory.
Item 8. (X one) Self-explanatory
Item 9. (X one) Answer Yes if participant is enrolled in a public school system or a Department of Defense Education Activity (DODEA) school system, otherwise answer No.

CHILD/YOUTH MEDICAL HISTORY (To be completed by the parent/legal guardian or custodian, or Agent acting pursuant to a power of attorney)
Item 10-35. Indicate with an X those that apply to the CYTP participant.
Item 36. Explanation for any items 10-35 with Xs.
Item 37. (X one) Answer Yes if the CYTP participant is enrolled in EFMP; otherwise, answer No.
Item 38. Self-explanatory.
Item 39. (X one) (Used to help determine if EFMP referral is necessary) Answer Yes if the CYTP participant has ongoing medical concerns or special needs/considerations that have required the care of a Healthcare Provider within the last year. Otherwise answer No. If yes, provide explanation of the medical concerns or special needs/considerations and indicate if the matter has been resolved. If yes, Page 2 must be completed by the Healthcare Provider of the CYTP participant.

PHYSICAL EXAMINATION (To be completed by Healthcare Provider)
Item 40. Height. Self-explanatory. If the CYTP participant has had a physical within the last 12 months, the Healthcare Provider may mark through the item and attach a copy of that physical in lieu of completing this item.
Item 41. Weight. Self-explanatory. If the CYTP participant had a physical within the last 12 months, the Healthcare Provider may mark through the item and attach a copy of that physical in lieu of sign, date and stamp (if applicable) the form.
Item 42. BP. CYTP participant's blood pressure. If the CYTP participant has had a physical within the last 12 months, the Healthcare Provider may mark through the item and attach a copy of that physical in lieu of completing this item.
Item 43. HR. CYTP participant's heart rate. If the CYTP participant had a physical within the last 12 months, the Healthcare Provider may mark through the item and attach a copy of that physical in lieu of completing this item.
Item 44 - 57. (X all that apply) X N/A if area unexamined. If the CYTP participant has had a physical within the last 12 months, the Healthcare Provider may mark through these items and attach a copy of that physical in lieu of completing these items.
Item 58. Explanation of any items 44 - 57, if abnormal. If the CYTP participant has had a physical within the last 12 months, the Healthcare Provider may mark through the item and attach a copy of that physical in lieu of completing this item.

Item 59. (X one) Answer Yes if all of the CYTP participant's immunizations, including tuberculin skin test (if applicable), are up-to-date at the time that this form is being completed. Otherwise, answer No and provide explanation. A copy of the CYTP participant's immunizations must be provided to CYTP. If the CYTP participant is on a catch-up schedule, a copy of the schedule must be provided to CYTP.
Item 60. Answer Yes if CYTP participant will be able to participate in NORMAL CYTP programs. Otherwise, answer No and provide explanation.
Item 61-62. The parent/legal guardian or custodian, or Agent acting pursuant to a power of attorney must sign and date the form.
Item 63-66. Self-explanatory. If more than one Healthcare Provider completed form, each must sign and date the form.
Item 67. Self-explanatory

HEALTH SCREENING TOOL FOR INCLUSION ACTION TEAM (IAT)
(To be completed by parent and Healthcare Provider or appropriate specialist)
Item 68. (X all that apply) Self-explanatory.
Item 69. Provide explanation of all Xs in Item 68.

MEDICATION (to be completed by Healthcare Provider or appropriate Specialist)
Item 70. Answer Yes if participant is medications related to special needs noted in Items 68-69. Otherwise, answer No.
Item 71. Answer Yes if participant has a prescribed Epinephrine injector. Otherwise, answer No.
Item 72. Answer Yes if participant has prescribed emergency medications other than epinephrine. Otherwise, answer No.
Item 73-76. Complete if participant is taking any medications. If Yes is chosen for Items 70-72, complete. Provide name, dose and how often medication is given. X if medication will need or possibly need to be given during childcare hours.
Item 77. Answer Yes if participant requires assistance with activities that are typically part of everyday life for a child of that age. Otherwise, answer No. If Yes, explain the assistance that is needed.
Item 78. Answer Yes if participant requires modifications to diet due to specific medical reasons. Otherwise, answer No. If Yes, explain required modifications. DO NOT provide dietary modifications that are due to religious, cultural or philosophical reasons.
Item 79. Answer Yes if participant requires environmental adaptations. Otherwise, answer No. If Yes, explain.
Item 80. Answer Yes if participant requires any other adaptations or modifications, or if there are any other recommendation or comments needed to explain special needs of child. Otherwise, answer No. If Yes, explain.
Item 81-85. Self-explanatory. Must be completed for form to be valid.
Item 86. CARRY AND SELF-ADMINISTER AUTHORIZATION (to be initiated by the Healthcare Provider). Initial one. Participant must be considered a Youth (including Teams) and NOT be in Child Development Programs (Child Development Centers, Family Child Care, or School Age Care). Self-explanatory.

EARLY INTERVENTION AND SPECIAL EDUCATION (to be completed by parent/legal guardian or custodian, or Agent acting pursuant to a power of attorney)
Item 87. Answer Yes if participant has IFSP or IEP. Otherwise, answer No. If Yes, proceed to Item 88-89.
Item 88. Self-explanatory.
Item 89. Self-explanatory.
Item 90-91. Self-explanatory.

OFFICE USE ONLY (to be completed by CYTP Nurse or Other Designated Personnel)

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