

Marine Corps Child & Youth Programs (CYP) Health Assessment

OMB No. 0703-0068

OMB approval expires
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Privacy Act Statement

In accordance with the Privacy Act of 1974 (Public Law 93-579), this notice informs you of the purpose for collection of information on this form. Please read it before completing the form.

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 NM01754-3](#)

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

RECORD MANAGEMENT: This form shall be managed in accordance with record schedule 1000-39, "Family Support Programs (Temporary)" of SECNAV M-5210.1.

The public reporting burden for this collection of information, OMB No. 0703-0068, 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 whs.mc-alex.esd.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.

SPONSOR INFORMATION (please print)

1. Name of Sponsor	2. Home Phone	3. Sponsor Unit
	4. Cell Phone	5. Duty/Work Phone

CHILD/YOUTH INFORMATION (please print)

6. Name of Child/Youth	7. Birth Date	8. <input type="checkbox"/> Male <input type="checkbox"/> Female	9. Enrolled in Public School <input type="checkbox"/> Yes <input type="checkbox"/> No
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CHILD'S/YOUTH'S MEDICAL HISTORY (Check all that apply)

10. Any hospitalization or operations	23. Heat stroke or exhaustion	36. If any apply, please explain
11. Allergies to medicine, insect bites, latex or food (please explain reactions)	24. Benign Skin Colorations (e.g. birthmarks)	
12. Development delays/Learning problems	25. Joint injuries	
13. Eye or vision Problems (Glasses/Contacts)	26. Restricted physical activity	
14. Ear or hearing problems	27. Diabetes	
15. Seizures or Convulsions	28. Cancer	
16. Dizziness or fainting with exercise	29. Dental problems	
17. Headaches	30. Mental Health Issues	
18. Head injury or loss of consciousness	31. Sleep problems	
19. Neck or back injury	32. Behavioral problems	
20. Asthma or difficulty breathing	33. ADD/ADHD	
21. Heart or blood pressure problems	34. Broken bones or sprains	
22. Chest pain with exercise	35. Other problems	

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.

Name of Child/Youth	Child Birth Date
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PHYSICAL EXAMINATION (To be completed by Healthcare Provider)(May attach last physical if within last 12 months)

40. Height:	41. Weight:	42. BP:	43. HR:	58. Based on this examination, the following abnormalities were found	
	Normal	Abnormal	N/A		
44. Eyes					51. Chest/ Abdomen
45. ENT					52. Genitalia
46. Hearing					53. Skin
47. Mouth/Teeth					54. Lymphatic
48. Neck					55. Spine
49. Cardiovascular					56. Extremities
50. Respiratory					57. Neurological

59. Immunizations are current and up to date Yes No (if no, please explain) **A copy of the child/youth immunization must be given to CYP.**

60. Child/Youth is able to participate in normal CYP programs? Yes No (if no, please explain)

61. Date	62. Parent or Guardian Signature	67. Healthcare Provider Stamp or Printed Name & Address
63. Date	64. Healthcare Provider Signature	
65. Date	66. Healthcare Provider Signature	

Name of Child/Youth	Child Birth Date
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**USMC Child and Youth Programs (CYP)
Health Screening Tool for Inclusion Action Team (IAT)**

REQUIRED ONLY IF THE CHILD/YOUTH HAS SPECIAL NEEDS/CONSIDERATIONS. TO BE COMPLETED BY PARENT AND HEALTHCARE PROVIDER OR APPROPRIATE SPECIALIST

Identification of Child/Youth Special Need(s) (use provided space to elaborate on the special need)

68. What special need(s) does the child/youth have?

Asthma/Reactive Airway Disease Allergies (other than seasonal/allergic rhinitis) Behavioral Neurological
Developmental (e.g. Autism/PDD/Delays) 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 (If more space is needed, please attach additional documents)

73. Name	74. Dosage	75. Frequency	76. During Child Care
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

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)

81. Healthcare Provider or Specialist Signature

82. Date

83. Provider/Specialist Stamp or Printed Name & Address

84. Phone

85. E-mail

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

I have instructed this youth in the proper way to use his/her medication. It is my professional opinion that he/she SHOULD be allowed to carry and self administer his/her medication. This youth has been instructed not to share medications.

It is my professional opinion that this child/youth SHOULD NOT carry or self administer his/her medication.

For youth who self-administer and carry their own medication(s), the medication MUST accompany the youth at all times. The options of storing "back up" rescue medications at the program is available. The youth must not share medications. Should the youth violate these restrictions the privilege of self medicating will be revoked and the youth parents notified. Youth are required to notify staff when carrying medication upon check in at CYTP activity. *Rescue medications MUST accompany children/youth during any off-site activities.

Early Intervention and Special Education

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

I understand that all reasonable efforts will be made to accommodate all properly documented special needs based on IAT determinations. Parent/guardian(s) will be notified if care accommodations cannot be honored and invited to attend subsequent meetings. I acknowledge that CYTP is not responsible for providing the child/youth with services that would be considered skilled nursing or behavioral, occupational, or physical therapy.

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

Office Use Only-Reviewed by CYP Nurse or Other Designated Personnel

92. Signature

93. Date

94. IAT Meeting date if required

INSTRUCTIONS FOR COMPLETING NAVMC 1750/4

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 Child and Youth Programs (CYP) 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 CYP 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 CYP 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 CYP 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 CYP participant.
 Item 36. Explanation for any items 10-35 with Xs.
 Item 37. (X one) Answer Yes if the CYP 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 CYP 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 CYP participant.

PHYSICAL EXAMINATION (To be completed by Healthcare Provider)

- Item 40. Height. Self-explanatory. If the CYP 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 CYP 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 sign, date and stamp (if applicable) the form.
 Item 42. BP. CYP participant's blood pressure. If the CYP 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. CYP participant's heart rate. If the CYP 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 44 - 57. (X all that apply) X N/A if area unexamined. If the CYP 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 CYP 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 CYP 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 CYP participant's immunizations must be provided to CYP. If the CYP participant is on a catch-up schedule, a copy of the schedule must be provided to CYP.

Item 60. Answer Yes if CYP participant will be able to participate in NORMAL CYP 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 need.

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 initialed by the Healthcare Provider). Initial one. Participant must be considered a Youth (including Teens) 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 CYP Nurse or Other Designated Personnel).