AIR FORCE YOUTH PROGRAMS REGISTRATION

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 U.S.C. 8012 and 44 U.S.C. 3101.
PRINCIPLE PURPOSES: To register dependent youth of military, retired and DoD personnel in the Air Force Youth Programs. Providing Youth Programs the authorization for medical treatment in emergency situations; authorization for transportation; record youth/family information; photo use authorization; and releasing of liability.
ROUTINE USES: This form may be disclosed to any DoD component or part thereof, and upon request to other Federal, State and local government agencies in the pursuit of their official duties; disclosed to news media; used for other lawful purposes including law enforcement and litigation.
DISCLOSURE IS VOLUNTARY: Failure to provide the information may preclude the individual from participation in Air Force sponsored youth programs.

YOUTH NAME LAST, FIRST, MI	SPONSOR NAME / RANK LAST, FIRST	SPOUSE NAME / RANK LAST, FIRST	EMERGENCY CONTACT OTHER THAN PARENT
BIRTHDATE / AGE	ORGANIZATION	HOME ADDRESS	EMERGENCY PHONE SAME AS CONTACT
MALE / FEMALE	WORK PHONE	WORK PHONE	PHOTO PERMISSION YES / NO
YOUTH HOME EMAIL	CELL PHONE	CELL PHONE	SPONSOR WORK EMAIL
HOBBIES & INTERESTS	SPONSOR SS # (LAST 4)	HOME PHONE	PARENT VOLUNTEER YES / NO

SPECIAL NEEDS CARE / ILLNESS / ALLERGIES / INJURIES

RELEASE OF LIABILIITY AND AGREEMENTS

MEDICAL CARE AUTHORIZATION: I hereby authorize my child to receive emergency medical treatment whenever it is deemed necessary at any U.S. Military Facility or any other medical facility when a U.S. Military Medical Facility is not avaliable.
HOLD AND SAVE HARMLESS AGREEMENT: Now therefore, in consideration of mutual covenants and agreements between the parties here to it is agreed as follows: We the parents of the above named youth agree to save and hold harmless as well as defend the Base Youth Programs, Services Division's Central Base Fund, Department of the Air Force and the contractor from and against any and all claims, demands, actions, debts, liabilities and attorney's fees. Parent further agrees to save and hold harmless the contractor and all other parties involved from and on account of damages of any kind which the youth may suffer as a result of the acts of participating in the program.
TRANSPORTATION/FIELD TRIP: I give Youth Programs permission to transport the aboved named youth to and from any events that I am notified of in advance.

SIGNATURE OF PARENT/LEGAL GUARDIAN	DATE

FOR USE BY YOUTH PROGRAM STAFF (COMPLETE & INITIAL)

PROGRAM ORIENTATION DATE	MEMBERSHIP CARD ISSUE DATE	MEMBERSHIP CARD NUMBER
EXPIRATION DATE	MEMBERSHIP FEE PAID	STAFF INITIAL / DATE

Form A *(to be completed by parent/guardian)*

Eielson AFB
Child and Youth Program
Inclusion Action Plan

PART A. To be completed by the parents/guardians.

Child's name: ___________________________ DOB: __________________Date: ______________

Circle one: Hourly Care Full Time Care Part Day Preschool Before & After School Youth Sports

Sponsor's name: ____________________________________ Email_________________________________

Spouses' name: _____________________________________Email_________________________________

Home phone: ______________________________ Cell phone: ____________________________________

Does your child have allergies, developmental delays, behavioral concerns or any other medical condition?

Check a box. **Yes** (Proceed to Part B). **No** (DO NOT PROCEED) ______________________________________
(Parent/Guardian signature)

PART B. Parents/guardians, check the appropriate box or boxes, get the appropriate paperwork and have it signed by a physician.

CHRONIC CONDITIONS		
Form D Required ☐ Respiratory (Asthma) **Form E Required** ☐ Seizure Disorder **Form F Required** ☐ Diabetes	**Form B Required** ☐ Blindness/Vision Condition ☐ Heart Condition ☐ Kidney Condition ☐ Deafness/Hearing Condition ☐ Developmental Delay ☐ Cerebral Palsy ☐ Atopic Disease	**Form B Required** ☐ Speech Concern ☐ Autism Spectrum ☐ ADHD ADD ☐ Anxiety ☐ Behavioral Concerns ☐ Other ______________________ _______________________________ _______________________________
Provide details for checked items (month and year with current status) :		

DIETARY AND FEEDING CONCERNS		
Form C Required		
☐ Food Allergies ☐ Feeding Concerns	☐ Special Diet Statement Provided ☐ Swallowing Difficulty/Aspiration risk	☐ Other ___________________ _________________________
Provides details for checked items: ____ ____ ____		

Updated 25 February 2019

Verified Information is complete _________

Form A *(to be completed by parent/guardian)*

Does your child/youth receive special services/therapies? Yes No Please specify:

____

Is your child/youth enrolled in the EFMP? Yes No Please specify

____

I acknowledge the information about my child will be shared with the Inclusion Action Team, Child and Youth Program personnel, and/or medical professionals in order to receive individualized recommendation for accommodations and support.

____________________________________   ____________________________

Parent's signature   Date

Verified Information is complete _________