

**Health Assessment / Sports Physical Statement
for CYS SERVICES
ENROLLEMENT & SPORTS Physical Requirements**

Revised Dec 08

DATA REQUIRED BY THE PRIVACY ACT OF 1994

PRINCIPAL PURPOSE: Information is used by DA personnel to: (1) verify child health status of immunization per admission requirements; (2) note special program considerations or restriction on child participation; (3) execute emergency medical procedure for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program; (5) certify physically fit to participate in sports. **ROUTINE USES:** No information is disclosed outside DOD. **DISCLOSURE:** Information is voluntary; however, if information is not provided, individuals may not be able to participate in community activities.

INSTRUCTIONS: All sections A, B, C. must be completed

PART: A Medical History (Filled out by parent / guardian)

Name of Sponsor	Home Telephone	Duty/Work Telephone
	Cell Telephone	
Sponsor Unit / Work Address	Sponsor SSN	Spouse's Work Telephone

CHILD HEALTH INFORMATION

Name of Child	Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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Does your child have ongoing medical concerns?
(If Yes, explain circumstances and current status)
 Yes No

Is your child enrolled in Exceptional Family Member Program?
(If Yes, explain)
 Yes No

MEDICAL HISTORY

	YES	NO		YES	NO
1. Any hospitalization or operations			14. Heat stroke or exhaustion		
2. Allergies to medicine, insect bites or food			15. Broken bones or sprains		
3. Speech or development delays			16. Joint injuries (Ankle/Knee/Wrist)		
4. Vision Problems (Glasses / Contacts)			17. Required restricted physical activity		
5. Ear or hearing problems			18. Diabetes		
6. Seizures or Convulsions			19. Cancer		
7. Dizziness or fainting with exercise			20. Dental or orthodontic braces		
8. Headaches			21. Learning problems		
9. Head injury or loss of consciousness			22. Sleep problems		
10. Neck or back injury			23. Behavioral problems		
11. Asthma or difficulty breathing			24. ADD / ADHD		
12. Heart or blood pressure problems			25. Autism Spectrum Disorder		
13. Chest pain with exercise			26. Other (please list below)		

If you answer yes to any of the above, please explain:

Ongoing Medications

Name	Dosage	Frequency

Allergies – All Types (Foods, Medicines and Insect Bites)

Type	Reaction

PART B: Physical Exam

Medical Staff Assessment (Completed by licensed independent practitioner; Doctor-Dr., Nurse Practitioner-NP, Physician's Assistant-PA)

Age YRS	MOS	Height cm. (%ile)	Weight kgs. (%ile)
BP: P:	/	Visual Acuity Right / Left /	Tested with / without glasses
		NORMAL	ABNORMAL
		N / A	COMMENTS
1. Eyes			
2. Ears, Nose & Throat			
3. Hearing			
4. Mouth & Teeth			
5. Neck (Soft tissues)			
6. Cardiovascular			
7. Chest & Lungs			
8. Abdomen			
9. Genitalia – Hernia			
10. Skin & Lymphatics			
11. Spine – Scoliosis			
12. Extremities			
13. Neurological			
14. Wears braces / plates			

Based on this HX and PX exam, the following abnormalities were found and may need treatment:

Immunizations are current and up to date: Yes No

PARTICIPATION RECOMMENDATIONS

All sports ____ Yes ____ No Normal physical activity to including PE
 Additional comments: Restrictions:

Sports Physical is valid for 1 year from date indicated below

PART C

Special Medical Considerations: Describe any special program needs, considerations or restrictions which the child requires in order to participate in CYS programs (to include Sports).

Child / Youth is able to participate in normal CYS programs? Yes No

Date Licensed Health Care Professional Stamp Licensed Health Care Professional; Dr., NP or PA Signature

Initial Date Type or print name of Parent or Guardian Signature of Parent or Guardian

Health Assessment Renewal (Not Part of the Sports Physical)

Year 2 Date Health Status Changed Signature of Parent or Guardian

Yes No

Year 3 Date Health Status Changed Signature of Parent or Guardian

Yes No