

AIR FORCE YOUTH FLIGHT PROGRAM PATRON REGISTRATION

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 8013; 44 USC 3101; EO 9397

PRINCIPAL PURPOSES: To provide Youth Flight Programs with authorization for medical treatment in emergency situations; authorization for field trips; identify children and sponsor, record required immunizations; record known allergies; record income data; record special needs requirements; and record special instructions.

ROUTINE USES: Form may be furnished to civilian doctors or hospitals in course of obtaining emergency medical attention for children. Information furnished may be disclosed, upon request, to other Federal, state or local governmental agencies in the pursuit of their official duties. Finally, it may be used for other lawful purposes including law enforcement and litigation.

DISCLOSURE IS VOLUNTARY: Failure to furnish information, including SSN, will result in denial of admission of child/(ren) to Youth Flight Programs. SSN is used for positive identification of individuals and records.

CHILD'S NAME (LAST, FIRST)	SPONSOR (LAST, FIRST, MIDDLE INITIAL)	SPOUSE (LAST, FIRST, MIDDLE INITIAL)	FEE'S
HOME PHONE	RANK/GRADE	RANK/GRADE	DEROS/ID EXPIRES
ADDRESS (MAILING)	DUTY PHONE (WORK)	DUTY PHONE (WORK)	BRANCH OF SERVICES
	ORGANIZATION	EMERGENCY CONTACT NAME	EMERGENCY PHONE #
	PARENT'S MARITAL STATUS	SPONSOR'S SSN	SPOUSE'S SSN
			HOSPITAL PHONE
			PHYSICIAN'S NAME

VACCINE / DATE RECEIVED	BIRTH	2 MOS	4 MOS	6 MOS	12 MOS	15 MOS	18 MOS	4-6 YRS	11-12 YRS	14-16 YRS	SEX (X One)	DATE OF BIRTH (Day, Month, Year)		
												MALE	FEMALE	
Hepatitis B 1st	Hep B-1												I authorize emergency treatment for the children named hereon: (PRINT CHILD'S NAME)	
2nd														
3rd	Hep B-2		Hep B-2						Hep B					
4th														
Diphtheria-Tetanus, Pertussis 1st													PARENT SIGNATURE	DATE (YYYYMMDD)
2nd													SPECIAL INSTRUCTIONS	
3rd		DTP	DTP	DTP	DTP			DTP OR DTAP	Td					
4th														
5th														
6th														
H. Influenzae type b 1st														SPECIAL NEEDS CARE / CHRONIC ILLNESSES / ALLERGIES
2nd														
3rd		Hib	Hib	Hib	Hib									
4th														
Polio 1st													ADULTS AUTHORIZED TO SIGN CHILDREN IN / OUT (OTHER THAN SPONSOR OR SPOUSE)	
2nd														
3rd		OPV	OPV	OPV				OPV						
4th														
Measles, Mumps, Rubella 1st													OTHER IMMUNIZATIONS AS REQUIRED:	
2nd														
Varicella Zoster Virus Vaccine 1st													NAMES OF ADDITIONAL CHILDREN ENROLLED IN PROGRAM:	
2nd														

OTHER IMMUNIZATIONS AS REQUIRED:	NAMES OF ADDITIONAL CHILDREN ENROLLED IN PROGRAM:	(PARENT SIGNATURE) AUTHORIZED FOR FIELD TRIPS
VACCINE TYPE: Hep A (2) DATE:		
VACCINE TYPE: Rota Virus (3) DATE:		
VACCINE TYPE: Flu (Annual) DATE:		
VACCINE TYPE: PCV (4) DATE:		

FAMILY INCOME (Adjusted gross—most recent 1040): PROVIDE ONLY IF REDUCED FEES ARE REQUESTED. \$ _____ SINGLE / DUAL INCOME (Circle One) \$ _____	IT IS THE RESPONSIBILITY OF EACH SPONSOR TO ENSURE IMMUNIZATIONS AND EMERGENCY INFORMATION IS UP TO DATE. FAILURE TO UPDATE MAY RESULT IN REFUSAL OF SERVICE.
PARENT SIGNATURE	

Sponsor Email: _____
Spouse Email: _____

Sponsor Cell Phone: (____) _____
Spouse Cell Phone: (____) _____

Child Placement Questionnaire
Fairchild AFB Child and Youth Programs

Child's Name: _____

Date of Birth: _____

Facility: _____

Today's Date: _____

1. Does your child have any of the following conditions? (Please mark)

- | | |
|--|---|
| <input type="checkbox"/> a. Visual Impairments/Blindness | <input type="checkbox"/> j. Asthma/Respiratory Problems |
| <input type="checkbox"/> b. Hearing Impairments | <input type="checkbox"/> k. Speech/Language Delays |
| <input type="checkbox"/> c. Physical Disabilities | <input type="checkbox"/> l. Allergies (meds, food,) |
| <input type="checkbox"/> d. Kidney Problems | <input type="checkbox"/> m. Behavior/Conduct Concerns |
| <input type="checkbox"/> e. Epilepsy/Seizures | <input type="checkbox"/> n. Diabetes |
| <input type="checkbox"/> f. Autism/PDD | <input type="checkbox"/> o. Attention Deficit/Hyperactivity
(ADHD/ADD) |
| <input type="checkbox"/> g. Heart Problems | <input type="checkbox"/> p. Learning Disability |
| <input type="checkbox"/> h. Hemophilia/Sickle Cell | <input type="checkbox"/> q. Other |
| <input type="checkbox"/> i. Developmental Delays | |

2. Please explain any condition marked above:

3. Is your child taking any medication for his/her condition? If so, please specify.

4. Is your child receiving Physical, Occupational, or Speech Therapy? If so, please explain.

5. Is your child receiving services from At Risk or Developmental Preschool (ECEAP, Michael Anderson) or Pediatric Behavioral Medicine? Yes No If yes, please explain.

6. Does your child have an IFSP, IEP or Treatment/Therapy/Behavior Plan? Yes No

7. Are you enrolled in the Exception Family Member Program (EFMP)? Yes No

Signature of Parent/Sponsor/Guardian

Home/Duty Phone

IF YOU ANSWERED YES TO ANY OF THE ABOVE, THE FORM WILL BE FORWARDED TO THE MEDICAL ADVISOR. PLEASE NOTE THAT WE WILL NEED MEDICAL DOCUMENTATION FOR ANY ALLERGIES OR SPECIAL NEEDS TO GUIDE STAFF TRAINING AND ENSURE YOUR CHILD'S INDIVIDUAL NEEDS ARE BEING MET.



Fairchild AFB Child Development Center
Topical Lotion & Photograph/Video Release

Child(ren)'s Name: _____ Date: _____

Topical Lotions Release

I authorize and give consent for the Child Development Program to apply diaper cream, sunscreen, lip balms, over-the-counter hand lotions, and hand-sanitizer. I understand all topical lotion options have been approved by the Medical Advisor and only those listed on the approved letter may be brought into the program. A copy of the approval letter may be obtained from the front desk.

Parent Signature

Photograph/Video Release

I authorize and give consent to the photographing of my child(ren) and understand that any videos and photographs of my child(ren) may only be used in a specific reference to the Child Development Program for promotion, publicity or recognition purposes of the Center.

Additionally, I understand that other parents in the program may take photographs or video classroom activities to record their own child(ren)'s history. I understand that my child(ren) may occasionally be photographed in this process.

I understand that the Child Development Center may share photographs or videos with parents for the purpose of sharing classroom experiences. These photographs, if shared electronically, cannot be used on any social media websites.

I understand that this release is valid until my permission is withdrawn in writing or until the child is withdrawn from the program.

Parent Signature

Child and Adult Care Food Program ENROLLMENT/INCOME-ELIGIBILITY APPLICATION

PART 1 - CHILDREN'S INFORMATION—Required for all children in care

Child's Name	Birthdate	Age	Circle Normal Days/ Print Normal Hours of Care	Circle Meals and Snacks Normally Received		
				Breakfast P.M. Snack	A.M. Snack Supper	Lunch Eve. Snack
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____			
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____			
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____			
			Sun Mon Tu Wed Th Fri Sat Normal Hours _____ to _____			

INCOME ELIGIBILITY

Please check the boxes that apply to help determine the other parts of this form to complete:

- A family member in our household receives benefits from Basic Food, TANF, or FDIPIR. (Please complete Part 2 and 5.)
- One or more of the children in Part 1 is a foster child. (Please complete Part 3 and 5.)
- My child(ren) may qualify for Free/Reduced-Price meals based on household income. (Please complete Part 4 and 5.)
- My child(ren) will not qualify for Free/Reduced-Price meals. (Please complete Part 5 only.)

PART 2 – HOUSEHOLD MEMBER RECEIVING BASIC FOOD, TANF, OR FDIPIR—Only one household member receiving benefits must be listed in order to establish eligibility for all children in the household.

Name	Circle One			Case Number or Identification Number
	Basic Food	TANF	FDPIR	

PART 3 - FOSTER CHILDREN—List the names of any children listed in Part 1 who are foster children

PART 4 - TOTAL HOUSEHOLD INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2

List Names (First and Last) of everyone in your household, including foster children	Gross Income from Last Month (if None, Write "0") (or net income if self-employed)			
	Earnings from Work Before Deductions	Alimony, Child Support, Welfare	Retirement, Pensions, Social Security	Job Two or Any Other Income
1.				
2.				
3.				
4.				
5.				
6.				
7.				

PART 5 - SIGNATURE AND CERTIFICATION - REQUIRED

The adult household member who fills out the application must sign below. If Part 4 is completed, the adult signing the form must also list the last four digits of his/her Social Security Number or check the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.) **If you have listed a case number in Part 2 or are applying on behalf of a foster child, or have checked the box that your child(ren) will not qualify for Free/Reduced-Price meals, the last four digits of the Social Security Number is not needed.**

I certify that all of the above information is true and correct and that all income is reported. I understand that this information is being given for the receipt of federal funds; that institution officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Signature of Adult	Date	Print Name of Adult Signing	<input type="checkbox"/> I do not have a Social Security Number
		Social Security Number (last four digits) XXX-XX-	
Address		City/State/Zip Code	Daytime Phone

PART 6 – CHILDREN’S ETHNIC AND RACIAL IDENTITIES—You are not required to answer this part.

Check the ethnic and racial category of your child. We need this information to be sure that everyone receives benefits on a fair basis.

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino

No child will be discriminated against because of race, color, national origin, gender, age, or disability.

Race:

- White
- Black or African American
- Asian
- American Indian or Alaskan Native
- Native Hawaiian or Pacific Islander
- Multi-Racial

If you feel you have been discriminated against, you should write USDA, Director of Civil Rights, 1400 Independence Avenue SW, Washington, DC 20250-9410.

PRIVACY ACT STATEMENT

The Richard B. Russell National School Lunch Act requires that, unless a household member's Basic Food, TANF, or FDPIR case number is provided or you are applying on behalf of a foster child, you must include the last four digits of the Social Security Number of the adult household member signing the application, or indicate that the household member does not have a Social Security Number. Provision of the last four digits of the Social Security Number is not mandatory, but if the last four digits of the Social Security Number is not provided or an indication is not made that the signer does not have a Social Security Number, the application cannot be approved in the free or reduced-price category. This notice must be brought to the attention of the household member whose last four digits of the Social Security Number is disclosed. The last four digits of the Social Security Number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the application. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a Basic Food or welfare office to determine current certification for receipt of Basic Food or TANF benefits, contacting the state employment security office to determine the amount of benefits received, and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal actions if incorrect information is reported.

CENTER USE ONLY

Foster child(ren) have been identified on this form and qualify for the free category.

Child(ren) on this form who are not foster children qualify as follows:

- Check one:
- Free Category
 - Reduced-Price Category
 - Above-Scale Category

Total Monthly Income \$ _____

This form must be signed and dated by the institution's representative.

Signature of Institution's Representative

Date