

CYP
TEEN PROGRAM
ENROLLMENT PACKET

2024/25

Manager's Signature: _____

Child and Youth Programs Accommodations Screening Form

Privacy Act Statement

Purpose: To provide child and family program eligibility and background information; to assist with child's placement in Camp Pendleton CYP Programs. Policies shall be implemented to ensure that appropriate services are provided for children, youth and teens with special needs. Such policies shall meet the requirement of the Rehabilitation Acts and the Department of Defense Directive 1020.1, Non Discrimination on the basis of Handicap in Programs and Activities Assisted or Conducted by the Department of Defense.

Routine Uses: This information will be shared with members of the Accommodations Collaboration Team (ACT) to assist with making an informed decision about your child's type of care. Information is used for program admission to ensure staff training is pertinent to the child's needs. Information is furnished for the attending physician when it is necessary for a child to be taken to a medical facility by someone other than the parent.

Disclosure: Disclosure of information is voluntary. If certain information is not shared, it may have an impact on CYPs ability to provide an accommodation or determine the best setting for your child. Please note any medication your child may take, or has taken consistently in the last six months.

Part I: General Information

Name of Child/Youth: _____ **DOB:** _____

Name of Sponsor: _____ **Branch:** USMC Navy Civilian Other: _____

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

Part II: Information About Your Child/Youth

	YES	NO		YES	NO
1. Does your child/youth require accommodations to participate in CYP? (Health condition, religious beliefs, dietary needs or modifications, etc.)			2. Has your child/youth been prescribed the following emergency medications? (Epipen, Albuterol inhaler, Diazepam, Glucagon)		
3. Does your child/youth take medication on a continual basis?			4. Does your child/youth have any mental, emotional, or behavior conditions?		

If yes, please explain: _____

5. Please check any that apply to your child/youth? None, my child does not have special needs.

- | | | |
|---|--|---|
| <input type="checkbox"/> Asthma/RAD | <input type="checkbox"/> Allergies (Food, environment, etc.) | <input type="checkbox"/> Food intolerance/sensitivity/substitutions |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> G-tube | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hearing difficulty | <input type="checkbox"/> Vision concerns | <input type="checkbox"/> Previous or Pending Surgeries |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Autism | <input type="checkbox"/> Developmental Delay |
| <input type="checkbox"/> Behavioral | <input type="checkbox"/> Neurological | |

If any, please explain: _____

6. Please check any special equipment your child/youth may use: None, my child does not use special equipment.

- Braces Walker Crutches Wheelchair Other

If any, please explain: _____

7. Please check any special services your child/youth receives: None, my child does not have special services.

- | | | |
|--|--|---|
| <input type="checkbox"/> Individual Family Service Plan (IFSP) | <input type="checkbox"/> Individualized Education Plan (IEP) | <input type="checkbox"/> 504 Plan |
| <input type="checkbox"/> Behavior Plan | <input type="checkbox"/> Applied Behavior Analysis (ABA Therapy) | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Physical Therapy | |
| <input type="checkbox"/> Aide/Skills trainer/Additional assistance | <input type="checkbox"/> Other | |

If any, please explain: _____

Part III: Parent/Guardian Signature

**By signing this form: 1) You confirm that you have provided full and complete information about your child/youth. 2) You are giving consent to the Accommodations Collaboration Team to review your child's submitted record. 3) You understand that CYP may require other information that may be needed about my child's medical condition, medication or treatment. 4) Questions about this form have been answered by CYP representative.*

Parent/Guardian Printed Name: _____ **Date:** _____

Parent/Guardian Signature: _____

Office Use Only

Notes/Comments:

CYP Representative Printed Name and Signature: _____ **Date:** _____

SPONSOR INFORMATION				
1. Name (First MI Last):				
2. Address:				
3. Command/Unit/Employer:				
4. Military Status:	5. Military Grade:	6. Branch:	7. Email:	
8. Home Phone:		9. Work Phone:		
10. Cell Phone:		10a. Cell Carrier:		
SPOUSE / GUARDIAN INFORMATION				
11. Name (First MI Last):				
12. Address:				
13. Command/Unit/Employer:				
13a. Full-time Student Post-Secondary Institution? <input type="radio"/> Yes <input type="radio"/> No				
14. Military Status:	15. Military Grade:	16. Branch:	17. Email:	
18. Home Phone:		19. Work Phone:		
20. Cell Phone:		20a. Cell Carrier:		
CHILD / YOUTH INFORMATION				
21. Child 1 First and Last Name:			Nick Name:	
Gender:	Birthdate:		School Grade (K-12 or N/A):	
Program Enrollment:	<input type="radio"/> Full Day <input type="radio"/> Part Day <input type="radio"/> Hourly <input type="radio"/> Family Child Care <input type="radio"/> School Age Care (BF/AF) <input type="radio"/> School Age Care (BF) <input type="radio"/> School Age Care (AF) <input type="radio"/> Summer Camp <input type="radio"/> Youth and Teen Program <input type="radio"/> Other:			
22. Child 2 First and Last Name:			Nick Name:	
Gender:	Birthdate:		School Grade (K-12 or N/A):	
Program Enrollment:	<input type="radio"/> Full Day <input type="radio"/> Part Day <input type="radio"/> Hourly <input type="radio"/> Family Child Care <input type="radio"/> School Age Care (BF/AF) <input type="radio"/> School Age Care (BF) <input type="radio"/> School Age Care (AF) <input type="radio"/> Summer Camp <input type="radio"/> Youth and Teen Program <input type="radio"/> Other:			
23. Child 3 First and Last Name:			Nick Name:	
Gender:	Birthdate:		School Grade (K-12 or N/A):	
Program Enrollment:	<input type="radio"/> Full Day <input type="radio"/> Part Day <input type="radio"/> Hourly <input type="radio"/> Family Child Care <input type="radio"/> School Age Care (BF/AF) <input type="radio"/> School Age Care (BF) <input type="radio"/> School Age Care (AF) <input type="radio"/> Summer Camp <input type="radio"/> Youth and Teen Program <input type="radio"/> Other:			
24. Please answer the following questions by marking either Yes or No:				
I allow use of video and photographs of my child within the CYP program.		<input type="radio"/> Yes <input type="radio"/> No	I give my permission for child to use supervised computers and internet.	
I approve my child/youth to attend field trips.		<input type="radio"/> Yes <input type="radio"/> No	I am aware of the DoD Priority Supplanting Policy	
I have received a copy or was given the website on where to get a "Parent Handbook".		<input type="radio"/> Yes <input type="radio"/> No		
LOCAL EMERGENCY CONTACT / RELEASE DESIGNEES (minimum of three contacts required)				
25. Name (First MI Last)	26. Address	27. Home Phone	28. Cell Phone	29. Relation to Child
30. Parent/Guardian Signature:			31. Date:	

**TEEN PROGRAM
COMPUTER USAGE FORM**

WARNING

This computer system, including all related equipment, networks and network devices (specifically including Internet Access), are provided only for authorized U.S. Government use. DOD computer systems may be monitored for all lawful purposes, including ensuring that their use is authorized, for management of the system, to facilitate protection against unauthorized access, and to verify security procedures, survivability and operational security. Monitoring includes active attacks by authorized DOD entities to test or verify the security of this system. During monitoring, information may be examined, recorder, copied and used for authorized purposes. All information, including personal information, placed on or sent over this system may be monitored. Use of this DOD Computer system, authorized or unauthorized, constitutes consent to monitoring of this system. Unauthorized use may subject you to criminal prosecution. Evidence of unauthorized use collected during monitoring may be used for administrative, criminal or adverse action. Use of this system constitutes consent to monitoring for these purposes.

RULES

1. Sign-in before using computers
2. No food or drinks of any kind are allowed around computer equipment.
3. You are not to access any adult or distasteful sites. (Adult content on government computers and networks is against Command Center Order 5230.1 and Federal Law)
4. You are not to access any Personal Classifieds, Dating Service, Matchmaker or Adult Clubs.
5. You are not to access Social Media Websites.
6. Do not change the workstation settings, delete files, install programs or download anything to the hard disk drive.
7. Do not switch computers without staff permission.
8. Do not shut down computers when finished.
9. Keep talking and audio CDs at low levels.
10. All workstations are subject to monitoring.
11. If you have any questions, please ASK.
12. If all workstations are occupied, a 30 minute time limit will be enforced.
13. Sign-out after using computers.

Please abide by these rules. If you violate these rules, you will be asked to sign out and your parent/guardian will be notified. Any violation of these rules may result in your computer usage being suspended for 30 days.

I, _____
Sponsor's Name (Please Print)

of minor child _____
Minor Teen's Name (Please Print)

Do hereby give permission for them to use computers with or without internet access.

This is to certify that I have read and understand the instructions and procedures for use of computer equipment and internet. I am aware of the restrictions for using the computer and internet access.

Sponsor's Signature

Date

Teen's Signature

Date

MEDICAL RELEASE

In the case of accident or injury, I hereby authorize medical treatment as the undersigned participant (or as the parent or guardian of the participant under 18 years of age) at the nearest medical facility. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care required. It is given to provide any and all such diagnosis or treatment care that any staff medical officer in the exercising of his or her best judgement may seem advisable. This authorization is given in pursuant to the provision of Section 25.A of the Civil Code of California.

(Sponsor's Initials): _____

STATEMENT OF UNDERSTANDING

I understand that there are various risks involved with my teen's participation in and enjoyment of the MCCS CYP activity. I understand that the risks of this activity include, but are not limited to injuries caused by the following: the negligence of other people in the vicinity, hot or inclement weather, hard surfaces on play equipment, irregular terrain, and physically challenging games or activity. I certify that the participant is physically able and has not been advised against strenuous play or recreational activity by a qualified health professional. I further agree that my teen will obey all MCCS CYP rules and verbal directives from MCCS CYP supervising adults. In consideration of participation in and enjoyment of the activity, I assume all risks associated with such activity and agree to indemnify, waive, release, and forever discharge the United States (U.S.) Government, the U.S. Marine Corps, Marine Corps Base, Camp Pendleton, MCCS, MCCS employees, and any other individuals or entities connected in any way to the MCCS CYP from any and all claims for damages, death, personal injury or property damage and litigation costs/attorney fees, arising from or contributed to, in whole or in part, by any act, omission, fault or mistake of the above-named persons or entities and their employees or agents, resulting from participation in the MCCS CYP activity. By affixing my initials, I affirm that I am the natural parent or legal guardian of the teen whose name appears at the top of this document, and that I have the legal capacity to act on behalf of that named teen.

(Sponsor's Initials): _____

PHOTO RELEASE

I, _____ hereby _____ give permission _____ do not give permission to use photographs, or videotape of my teen for the "Scout" base newspaper, fliers, or any form of advertisement for the CYP.

TEEN PROGRAM GUIDELINES

1. Hours of operation are from: 1400-1800 (M-T-TH-F) 1330-1800 (Wed). Teen Centers are closed on all Federal Holidays.
2. All Teens must have a verification of Annual Influenza Immunization prior to starting at the Teen Center.
3. The Teen Centers are not responsible for lost or stolen items/money. Please do not bring valuable items to the Teen Centers.
4. Members must sign-in and out daily and can only be on the premises during hours of operation.
5. No outside food or drinks may be brought into the site. We are also a nut free facility.
6. Obscene, boisterous and destructive behavior will not be tolerated.
7. Members will refrain from physical contact with other members and staff.
8. Members are not allowed in offices, kitchens, or janitor areas unless authorized by staff personnel.
9. Shirts and enclosed shoes must be worn at all times.
10. No refunds for fieldtrips unless canceled by Centers.
11. Members must remain in their seats and wear their seatbelt at all times while riding in a government vehicle or commercial buses.

TEEN MEMBER'S SIGNATURE: _____ DATE: _____

SPONSOR'S SIGNATURE: _____ DATE: _____



**INFORMED CONSENT AND WAIVER OF LIABILITY
PERMISSION FOR EMERGENCY EVACUATION**

Print Form

Privacy Act Statement

SORN NM01754-3

AUTHORITY: 10 U.S.C. 5013; Secretary of the Navy; 10 U.S.C. 5041, Headquarters, Marine Corps; DoD Instruction 6060.2, Child Development Programs; DoD Instruction 6060.3, School Age Care Program; DoD Instruction 6060.4, Youth Programs; OPNAV Instruction 1700.9 series, Child and Youth Programs; Marine Corps Order P1710.30E, Children, Youth, and Teen Program (CYTP); and E.O. 9397 (SSN), as amended.

PRINCIPLE PURPOSE: To develop childcare programs that meet the needs of children and families; provide child and family program eligibility and background information; and verify health status and immunizations of children.

ROUTINE USES: Provide information on sponsor and children seeking and receiving services under the Navy Child and Youth Program or the Marine Corps Children, Youth, and Teen Program.

DISCLOSURE: Disclosure of personal information is voluntary. However, if requested information is not provided, services cannot be rendered.

PLEASE NOTE THAT IN THE EVENT OF THE SPONSOR'S DEPLOYMENT, A POWER OF ATTORNEY WILL BE REQUIRED FOR SPONSOR'S INITIALS/SIGNATURE.

NAME OF CHILD PARTICIPANT: _____

AS PARENT/GUARDIAN OF THE MINOR CHILD, WHOSE NAME APPEARS AT THE TOP OF THIS PAGE, I GRANT MY PERMISSION FOR HIM/HER TO BE TRANSPORTED BY BUS, PERSONAL VEHICLE, OR WALKING BY MCCS CHILDREN, YOUTH AND TEEN PROGRAM (CYTP) IN THE EVENT OF A NATURAL DISASTER OR ACTS OF TERRORISM. ALL CHILDREN WILL BE EVACUATED TO A SAFE AREA PREVIOUSLY DESIGNATED BY EMERGENCY PLAN COORDINATORS.

I HEREBY ASSUME ALL RISKS ASSOCIATED WITH MY MINOR CHILD'S PARTICIPATION IN ANY CYTP EVACUATION AND AGREE TO INDEMNIFY, WAIVE, RELEASE, AND FOREVER DISCHARGE THE UNITED STATES (U.S.) GOVERNMENT; THE U.S. MARINE CORPS; MARINE CORPS BASE, CAMP PENDLETON; MCCS; MCCS EMPLOYEES AND ANY OTHER INDIVIDUALS OR ENTITIES CONNECTED IN ANY WAY TO THE MCCS CYTP, FROM ANY AND ALL CLAIMS FOR DAMAGES, DEATH, PERSONAL INJURY OR PROPERTY DAMAGE, AND LITIGATION COSTS/ATTORNEYS' FEES ARISING FROM OR CONTRIBUTED TO, IN WHOLE OR IN PART, BY ANY ACT, OMISSION, FAULT OR MISTAKE OF THE ABOVE-NAMED PERSONS OR ENTITIES AND THEIR EMPLOYEES OR AGENTS, RESULTING FROM MY HEREIN NAMED MINOR CHILD'S PARTICIPATION IN THE MCCS CYTP EVACUATION.

BY MY SIGNATURE BELOW, I AFFIRM THAT I AM THE NATURAL PARENT OR LEGAL GUARDIAN OF THE CHILD, WHOSE NAME APPEARS AT THE TOP OF THE PAGE, THAT I HAVE THE LEGAL CAPACITY TO ACT ON BEHALF OF THAT NAMED CHILD AND THAT I HAVE EXECUTED THE DOCUMENT ON BEHALF OF THE NAMED CHILD.

SIGNATURE OF SPONSOR: _____ DATE: _____

SIGNATURE OF MCCS CYTP WITNESS: _____



CHILD EMERGENCY INFORMATION

Print Form

Privacy Act Statement

SORN NM01754-3

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PRINCIPLE PURPOSE: To acquire necessary information in the event of an emergency to contact a parent or legal guardian to include: child's name, allergies, date of birth, mother's name, father's name, work, cell and home numbers, address, and three additional emergency contacts with name, home and work numbers. In the event either parent or legal guardian are unavailable, emergency contact numbers are utilized.

ROUTINE USES: Contacting appropriate individual to ensure safe pick up of child during an emergency or illness.

DISCLOSURE: Disclosure of personal information is voluntary. However, if information is not provided, records for emergency information will not be kept up to date.

CHILD'S NAME: _____ DATE OF BIRTH: _____ ALLERGIES: _____

MOTHER/GUARDIAN NAME: _____ RANK (If applicable): _____

ADDRESS: _____ CITY, STATE, & ZIP CODE: _____

WORK NUMBER: _____ CELL NUMBER: _____

FATHER/GUARDIAN NAME: _____ RANK (If applicable): _____

ADDRESS: _____ CITY, STATE, & ZIP CODE: _____

WORK NUMBER: _____ CELL NUMBER: _____

EMERGENCY CONTACT NUMBERS

NAME: _____ WORK NUMBER: _____ CELL NUMBER: _____

NAME: _____ WORK NUMBER: _____ CELL NUMBER: _____

NAME: _____ WORK NUMBER: _____ CELL NUMBER: _____

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