Marine Corps Air Station Yuma
Child and Youth Programs

REGISTRATION PACKET

Welcome to Child and Youth Programs (CYP). We are pleased you have chosen to enroll your child(ren) in one of our high-quality programs and welcome your family to ours! Life in the military creates some unique challenges but here at CYP, a large population of the staff that are military connected and understands the support required for family resiliency. CYP is committed to promoting optimal child development and family well-being through access to quality childcare. We look forward to having your child in our program and working together in sharing your child's growth and development.

CHILD AND YOUTH PROGRAMS OVERVIEW:

The Child Development Center (CDC) offers "full day" childcare for children 6 weeks old to 5 years old (not eligible for kindergarten). The center is accredited through the National Association for the Education of Young Children (NAEYC). Early Learning Matters (ELM) curriculum is implemented in the classroom. Hours of operation are 0600-1800 (subject to change).

The Youth Center (YC) offers before and after school care for children enrolled in kindergarten, 5 years up to 12 years of age. The YC is affiliated with the Boys and Girls Club of America (BGCA) and follows their curriculum. During school breaks "camps" are offered; Spring, Summer, Fall and Winter. Hours of operation are 0600-1800 (subject to change).

Family Child Care may be available and offers a home environment provided by a military connected spouse for children of all ages. Active-duty spouses interested in certifying their home, to provide childcare should contact he the Family Care Program Manager. These providers are background checked, certified, and monitored through CYP. Enrollment services for this childcare space is managed through the Resouece and Referral office. Hours of operation vary by home.

CLOSURES: All programs are closed for federal holidays. Other closures may occur depending on variable factors by Marine Corps Community Services and/or Marine Corps Air Station Command.

When searching for care, please visit www.militarychildcare.com. This website is applicable for all programs. Per the Secretary of Defense, a priority system has been established. Any child identified other than a 1A-B priority, as labeled in the MCC.com system, may be supplanted by another child with a 1A-B priority. A "Supplant Letter" with a 45days notice is issued to the family whose child will be removed from childcare to make pace for the child that has a higher priority. The child supplanted will be the last child enrolled in the program. Upon enrollment, patrons are required verification of priority, and this will be verified annually.

Items needed for enrollment:

- Completed Registration Packet (Encl)
    - *per NAVMC 1750.5- Local Emergency Contacts must be provided, to include address.*
- CYP Health Assessment Form (Encl)
- Child Immunizations Records, to include proof of Flu Vaccination
- Proof of Dependency (DEERS/BIR)
- Parents pay information: Leave & Earning Statement/Paystub
- Attend a Parent Orientation

For more information, please contact CYP Resource and Referral at (928) 269-3251 or (928) 269-3234

NAVMC 11906 (09-13) (EF)

Childs Name: _____

2025

U.S. Marine Corps Child and Youth Programs
What to bring to Resource and Referral (R&R)

Contact local R & R to set up an appointment to complete the registration package. To expedite the registration process, please have the following information available:

Parent Information Needed	
Complete Home Address (indicate if housing is on or off base)	
Complete Work Address	
Military Command/Unit (Branch of Service)	
Spouse/Guardian Work Address and Employer's Name	
Home, Work and Cell Phone numbers for yourself and spouse/ guardian.	
Email for yourself and spouse/guardian that is accessible during work hours.	
Current Leave and Earnings Statement (LES) for yourself and spouse. If spouse is a full-time student bring proof of school enrollment (This information is used to determine DOD Fee Category).	
3 Local (*must have base access & arrive within 59minutes*) emergency contacts for children and youth (*other than parents*). Full name and phone numbers are required.	
What type of care or service are you requesting?	

Child/Youth Information Needed	
Proof of DEERS *Date seen:*	
Child/Youth Official Shot Records	
Current Child/Youth Health Assessment	
Health Screening Tool for Inclusion Action Team (IAT) (If applicable)	
Child/Youth School and Grade	

APPLICATION FOR DEPARTMENT OF DEFENSE CHILD CARE FEES

(Read Instructions on back before completing form.)

OMB No. 0704-0515
OMB approval expires 20261031

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 3013, Secretary of the Army; 10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. 5041, Headquarters, Marine Corps; 10 U.S.C. 8013, Secretary of the Air Force; DoD Instruction 6060.02, Child Development Programs; Army Regulation 608-10, Child Development Services; OPNAV Instruction 1700.9E series, Child and Youth Programs; Marine Corps Order P1710.30E, Children, Youth, and Teen Program (CYTP); Air Force Instruction 34-144, Child and Youth Programs.

PRINCIPAL PURPOSE(S): To collect total family income to determine child care fees.

ROUTINE USE(S): Disclosure of records are generally permitted under 5 U.S.C. 522a(b) of the Privacy Act of 1974, as amended. Department of the Army records may be disclosed to bonafide Federal, State, or local social service or welfare organizations. Department of the Navy Records may be disclosed to local, State and Federal officials involved in Child Care Services, if required, in the performance of their official duties relating to child abuse reporting and investigations. Department of the Air Force records may be disclosed to civilian physicians or hospitals in the course of obtaining emergency medical attention for children.
Additional routine uses are listed in the following applicable System of Records Notice: Department of the Army: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570083/a0608a-cfsc/; Department of the Navy: https://dpcld.defense.gov/Privacy/SORNsindex/DOD-wide-SORN-Article-View/Article/570428/nm01754-3/; Department of the Air Force: https://dpcld.defense.gov/Privacy/SORNsindex/DOD-wide-SORN-Article-View/Article/569755/F034-af-sva-c/.

DISCLOSURE: Voluntary, however, failure to provide the required information will delay the processing and approval of child care services.

SECTION I - DEPENDENT CHILDREN

1. NAME OF EACH CHILD *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. AGE	4. CARE REQUESTED *(OR ENROLLED)*
a.			
b.			
c.			
d.			
e.			

SECTION II - ANNUAL FAMILY INCOME

5. SPONSOR

a. NAME *(Last, First, Middle Initial)*	b. YEARS OF MILITARY/CIVIL SERVICE

c. INCOME

(1) Income Data	(2) Basic Allowance for Housing (BAH)	(3) Basic Subsistence Allowance	(4) Other Earned Income	(5) Total Income - Sponsor (To be completed by Program Staff)

6. SPOUSE OR OTHER ADULT LIVING IN THE HOME

a. NAME *(Last, First, Middle Initial)*	b. INCOME

7. OTHER INCOME EARNED	8. TOTAL INCOME *(Include income from Blocks 5, 6, and 7. To be completed by Program Staff.)*

SECTION III - CERTIFICATION OF SPONSOR/DESIGNEE

(Required for all categories. Please read the following statement carefully before signing.)

I certify that all of the above information is true and correct and that all family income of the spouse and sponsor is reported. I understand that this information is being given in order to determine child care fees to be paid and that Federal funds are used to subsidize the cost of child care. I also understand that the installation commander may verify the information on the application, and that deliberate misrepresentation of this information may subject me to prosecution under applicable State and Federal laws. See 18 U.S.C. Section 1001.

9. SIGNATURE OF SPONSOR	10. SIGNATURE OF SPOUSE	11. DATE SIGNED *(YYYYMMDD)*

SECTION IV - FOR CHILD DEVELOPMENT PROGRAM USE ONLY

12. PRIORITY SYSTEM ELIGIBILITY	13. CATEGORY OF APPROVAL	14. AUTHORIZED FEES	15. DATE OF APPROVAL *(YYYYMMDD)*	16. NAME OF CHILD DEVELOPMENT PROGRAM OFFICIAL

INSTRUCTIONS

Per Department of Defense Instruction 6060.02, Child Development Programs, this form is utilized to determine fees for DoD Child Care Programs.

To determine child care fees for your child(ren), or and child(ren) you legally claim as dependents, this from must be completed, signed and returned to the facility for which your child is enrolling.

Fees are determined based on your Total Family Income (TFI) as defined below. TFI documentation is required for child care rate determination.

Total Family Income (TFI) - For the purpose of determining child care fees in DoD Child Development Programs, total family income is defined as all earned income including wages, salaries, tips, special duty pay (flight pay, active duty demo pay, sea pay) and active duty save pay, long-term disability benefits, voluntary salary deferrals, retirement or other pension income including SSI paid to the spouse and VA benefits paid to the surviving spouse before deductions for taxes. TFI calculations must also include quarters subsistence and other allowances appropriate for the rank and status of military or civilian personnel whether received in cash or in kind.

DO NOT INCLUDE alimony, and child support received by the custodial parent, SSI received on behalf of the dependent child, reimbursements for educational expenses or health and wellness benefits, cost of living (COLA) received in high cost areas, temporary duty allowances, or reenlistment bonuses.

For households in which unmarried couples or pairs are living as a family, the income for both adults should be used to determine Total Family Income (TFI).

Sections I, II, and III are to be completed by the sponsor or their designee.

Section I

1. Provide the last name, first name and middle initial for each child who is receiving care in a DoD child care program.

2. Provide the date of birth for each child who is receiving care in a DoD child care program.

3. Provide the age of each child on the date of application who is receiving care in a DoD child care program.

4. Provide the type of care being request or in which each child is currently enrolled.

Section II.

When completing Section II, include all military and civilian income for both the sponsor and spouse or other adult living in the home.

5.a. Provide the sponsor's last name, first name and middle initial.

5.b. Provide the total years of military/civilian service as applicable.

5.c.(1) Provide your most recent income data and indicate if income is received weekly, biweekly, monthly or twice per month.

5.c.(2) Provide the current year BAH RT/C. For dual military living in government quarters include BAH RC/T of the senior member only; in locations where military members receive less than the BAH RC/T allowance, use the local BAH rate; for Defense civilian OCONUS include either the housing allowance or the value of the in-kind housing.

5.c.(3) Provide the basic subsistence allowance or in-kind equivalent.

5.c.(4) Provide any other earned income.

5.c.(5) To be completed by program staff.

6.a. Provide the last name, first name and middle initial of the spouse or other adult living in the home, who contributes to the welfare of the child.

6.b. Provide the income of the spouse or other adult living in the home, who contributes to the welfare of the child.

7. Provide any additional income.

8. To be completed by program staff.

Section III.

9. Provide the sponsor's signature.

10. Provide the spouse's or other resident adult's signature.

11. Provide the date of signatures.

DEPARTMENT OF DEFENSE CHILD DEVELOPMENT PROGRAM
REQUEST FOR CARE RECORD

(Read Privacy Act Statement and Instructions on back before completing form.)

OMB No. 0704-0515
OMB approval expires 20231031

1. DATE OF REQUEST *(YYYYMMDD)*	2. EXPIRATION DATE *(YYYYMMDD) (To be completed by Facility)*

3. FAMILY INFORMATION

a. SPONSOR'S NAME *(Last, First, Middle Initial)*	b. SPOUSE'S NAME *(Last, First, Middle Initial)*	
c. CHILD'S NAME *(Last, First, Middle Initial)*	d. CHILD'S DATE OF BIRTH *(YYYYMMDD)*	e. CHILD'S AGE
f. HOME ADDRESS *(Street, City, State, Zip Code)*	g. SPONSOR'S BRANCH OF SERVICE	
	h. DUTY ORGANIZATION	
i. HOME TELEPHONE NUMBER *(Include Area Code)*	j. DUTY TELEPHONE NUMBER *(Include Area Code)*	

k. SIBLING CARE

(1) NAME *(Last, First, Middle Initial)*	(2) DATE OF BIRTH *(YYYYMMDD)*	(1) NAME *(Last, First, Middle Initial)*	(2) DATE OF BIRTH *(YYYYMMDD)*

4. PROGRAM(S) DESIRED *(X as applicable)*

	a. FULL-DAY CARE		d. FAMILY DAY CARE (FDC)
	b. PART-DAY CARE		e. PART-DAY ENRICHMENT
	c. SCHOOL AGE		f. PRE-SCHOOL

5. AGE GROUP *(X one)*

	a. INFANTS *(0 - 12 months)*
	b. TODDLERS *(13 - 35 months)*
	c. PRESCHOOL *(3 - 5 years)*
	d. SCHOOL AGE *(5+ years)*

6. SPONSOR STATUS *(X one)*

	a. SINGLE MILITARY		e. SINGLE DOD CIVILIAN		i. MILITARY/UNEMPLOYED SPOUSE
	b. DUAL MILITARY		f. RETIRED MILITARY		j. MILITARY/OTHER THAN DOD SPOUSE
	c. MILITARY/DOD SPOUSE		g. MILITARY RESERVE		k. OTHER *(Specify)*
	d. DUAL DOD CIVILIANS		h. NATIONAL GUARD		

7. PRESENT CHILD CARE ARRANGEMENTS *(X as applicable)*

	a. FCC ON-INSTALLATION		d. CIVILIAN CDC		g. IN-HOME CARE
	b. FCC OFF-INSTALLATION		e. MILITARY ALTERNATE CARE		h. NO PRESENT CARE
	c. OTHER MILITARY CHILD DEVELOPMENT CENTER (CDC)		f. NON-MILITARY ALTERNATE CARE		i. OTHER *(Specify)*

8. GENERAL INFORMATION *(X and complete as applicable)*

YES	NO		YES	NO	
		a. IF CHILD IS NOT PRESENTLY IN CARE, IS EMPLOYMENT OF SPOUSE IMPACTED? *(If Yes, estimate average annual income lost)*			c. IS CHILD ON OTHER MILITARY WAITING LIST? *(If Yes, name installation)*
		b. HAS CHILD BEEN IDENTIFIED FOR SPECIAL NEEDS CARE?	d. CURRENT COST OF CARE PER WEEK *(If child is currently in care)*		

9. ACCOMMODATION UPDATES/REVERIFICATION *(For Office Use Only)*

	(1)	(2)	(3)	(4)	(5)
a. DATE CALLED *(YYYYMMDD)*					
b. DECLINED/ PLACED					
c. COMMENTS/ INITIALS					
d. PLACEMENT TIME *(In months)*					

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 3013, Secretary of the Army; 10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. 5041, Headquarters, Marine Corps; 10 U.S.C. 8013, Secretary of the Air Force; DoD Instruction 6060.02, Child Development Programs; Army Regulation 608-10, Child Development Services; OPNAV Instruction 1700.9E series, Child and Youth Programs; Marine Corps Order P1710.30E, Children, Youth, and Teen Program (CYTP); Air Force Instruction 34-144, Child and Youth Programs.

PRINCIPAL PURPOSE(S): To collect applicant information for Child Development Programs and establish waiting lists for program services. This information may also be used for statistical analysis, tracking, reporting, and evaluating program effectiveness.

ROUTINE USE(S): Department of the Army records may be disclosed to civilian health and welfare departments/agencies in emergencies. Department of the Navy records may be disclosed to local, state and Federal officials involved in child care services, if required, in the performance of their official duties relating to child abuse reporting and investigations. Department of the Air Force records may be disclosed to civilian health and welfare departments/agencies in emergency situations.

When completed, records are covered by one of the appropriate SORNS:
Department of the Army: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570083/a0608a-cfsc/;
Department of the Navy: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570428/nm01754-3/;
Department of the Air Force: https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/569755/f034-af-sva-c/;

DISCLOSURE: Voluntary; however, if you fail to furnish the needed information, you might not be added to a waiting list or notified when there is space for your child.

INSTRUCTIONS

This form is to be completed by authorized patrons (per Department of Defense Instruction 6060.02, Child Development Programs) and serves as the Official Request for Care for use of Department of Defense operated Child Development Programs. Providing this information is voluntary, but failure to complete the form may result in a denial of care.

1. Provide the date the request is completed.

2. To be completed by facility where care is requested. This form expires one year from the initial date of request.

3. Family Information.

3.a. Provide the sponsor's last name, first name and middle initial.

3.b. Provide the spouse's last name, first name and middle initial (when applicable).

3.c. Provide the last name, first name and middle initial of the child for whom care is being requested.

3.d. Provide the date of birth of the child for whom care is being requested.

3.e. Provide the age of the child for whom care is being requested at the time of application.

3.f. Provide the residential address of the child for whom care is being requested.

3.g. Provide the sponsor's branch of service. For DoD civilians, provide the service or agency of employment. If this is not applicable, enter NA.

3.h. Provide the organization to which the sponsor is employed. If this is not applicable, enter NA.

3.i. Provide the home telephone number of the sponsor.

3.j. Provide the work telephone number of the sponsor.

3.k. If the family is requesting care for additional children, enter their last name, first name, middle initial and date of birth, and complete a separate form for each child when applicable.

4. Program(s) Desired.
   - Place an "X" to indicate the family's desire for where the child's need for care may be accommodated.

5. Age Group.
   - Place an "X" to indicate the age group that the child falls on the date of application.

6. Sponsor Status.
   - Place an "X" to indicate the status of the sponsor on the date of application.
   - For "Other", specify the sponsor's status.

7. Present Child Care Arrangements.
   - Place an "X" to indicate the present arrangement for child care of the child for whom care is being requested.
   - For "Other", specify the sponsor's status.

8. General Information.

8.a. Indicate "Yes" or "No" if the lack of child care is impacting the ability of the spouse (where applicable) to find employment.

8.b. Indicate "Yes" or "No" if the child has been identified for special needs care.

8.c. Indicate "Yes" or "No" if the child is on other military waiting lists for child care. If, "yes", provide the name of the installation where the child is on a waiting list.

8.d. If the child is currently accommodated in non-DoD child care, indicate the weekly cost for care.

9. To be completed by the facility only.

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? ◯ Yes ◯ 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:	◯ Full Day	◯ Part Day	◯ Hourly	◯ Family Child Care	◯ School Age Care (BF/AF)	◯ School Age Care (BF)
	◯ School Age Care (AF)	◯ Summer Camp	◯ Youth and Teen Program	◯ Other:		
22. Child 2 First and Last Name:					Nick Name:	
Gender:	Birthdate:				School Grade (K-12 or N/A):	
Program Enrollment:	◯ Full Day	◯ Part Day	◯ Hourly	◯ Family Child Care	◯ School Age Care (BF/AF)	◯ School Age Care (BF)
	◯ School Age Care (AF)	◯ Summer Camp	◯ Youth and Teen Program	◯ Other		
23. Child 3 First and Last Name:					Nick Name:	
Gender:	Birthdate:				School Grade (K-12 or N/A):	
Program Enrollment:	◯ Full Day	◯ Part Day	◯ Hourly	◯ Family Child Care	◯ School Age Care (BF/AF)	◯ School Age Care (BF)
	◯ School Age Care (AF)	◯ Summer Camp	◯ Youth and Teen Program	◯ 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.	◯ Yes	◯ No	I give my permission for child to use supervised computers and internet.	◯ Yes	◯ No
I approve my child/youth to attend field trips.	◯ Yes	◯ No	I am aware of the DoD Priority Supplanting Policy.	◯ Yes	◯ No
I have received a copy or was given the website on where to get a "Parent Handbook".	◯ Yes	◯ 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:

USMC CHILD AND YOUTH PROGRAMS REGISTRATION FORM

OMB No. 0703-0068

OMB Approval Expires 09/30/2025

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: Information provided is used by Children and Youth Programs (CYP) for purposes of patron registration in CYP programs and activities and parent/guardian and emergency contacts.
ROUTINE USES: Information will be accessed by CYP personnel with a need to know to meet the purpose. Information is not routinely disclosed outside of DoD. 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. A complete list and explanation of the applicable routine uses are published in the authorizing SORNs available at: https://dpcld.defense.gov/Privacy/SORNsIndex/DODwide-SORN-Article-View/Article/570428/nm01754-3/.
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 30 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.

INSTRUCTIONS FOR COMPLETING NAVMC 1750/5

GENERAL
This form is completed by the parent/legal guardian or custodian, or Agent acting pursuant to a power of attorney. Information provided is used by Child and Youth Programs (CYP) for purposes of participant registration in CYP programs and activities. At least annually or when the information is outdated a new form will be completed, signed, and dated.

SPONSOR INFORMATION
Items 1-3. Self-explanatory.
Item 4. Indicate Sponsor's status in the military.
Item 5. If applicable, indicate Sponsor's military grade, otherwise type "N/A".
Item 6. Indicate branch Sponsor is affiliated with.
Items 7-10. Self-explanatory.
Item 10a. Name of cell phone carrier.

SPOUSE / GUARDIAN INFORMATION
Items 11-20a. Please follow instructions for items 1-10a above as it relates to the spouse / guardian.

CHILD / YOUTH INFORMATION
Items 21-23. Self-explanatory. There are three sections provided on the form if the family is registering multiple participants. Please fill in one section for each participant.
Item 24. Answer Yes if use of video and photographs are allowed. Otherwise, answer No.
Answer Yes if participant is allowed to attend field trips. Otherwise, answer No.
Answer Yes if you received the Parent Handbook. Otherwise, answer No.
Answer Yes if participant is allowed to use computers and internet. Otherwise, answer No.
Answer Yes if you are aware of the DoD Priority Supplanting Policy. Otherwise, answer No.

LOCAL EMERGENCY CONTACT / RELEASE DESIGNEES
Items 25-28. Self-explanatory. These individuals will be contacted when the parents/guardians are unavailable and also have permission to depart the premises with the participant. There are three rows for multiple emergency contacts/release designees. Fill out one row for each emergency contact/release designee.
Item 29. Provide the relationship that the emergency contact/release designee has with the participant.
Items 30-31. Self-explanatory.

Marine Corps Community Services
Child and Youth Programs
Marine Corps Air Station
Yuma, AZ 85369-9132

PERMISSION SLIPS

FIELD TRIPS IN A VEHICLE (*For Preschool & School Age Care only*)

WAIVER OF LIABILITY (Vehicle or Bus)
Release executed on (MM/DD/YY)_____ by (Parent's Name)_____
(Parents address)_____ for passenger (Child's name)_____and (Child's name)_____ of the City of YUMA, County of YUMA, State of ARIZONA, in favor of the United States Government.
In consideration of receiving transportation for the United States Marine Corps by motor vehicles from the Child and Youth Programs or a Family Child Care Provider to a planned and approved destination, including such other transportation by this and other means that may be reasonably required, for the Year of 2025. I hereby release the United States Government including all its subdivisions, officers, military personnel DoD employees, and agents from all liability for any injuries or death that may result to me and/ or my child from this transportation, whether caused by negligence or otherwise. I understand that in transporting me and/or my child, the United States Government is not acting as a common carrier for hire and transportation. I also understand that I am under no obligation towards the United States Government except as imposed by this release. I agree that this release not only binds me, but also my family, heirs and assigns, administrators, and executors. I further state that I, _____ (parents name), have carefully read the foregoing release and know that contents thereof and sign this release as my own free act.

_____
Parent's Signature & Date

If I choose to deny permission, I may be responsible for finding alternate care for my child during the duration of the field trip. I also understand that if I choose to accompany the field trip, I will be responsible for my child. In addition, each trip that uses any of the above vehicles will have a separate permission slip with the specific times, dates, and destination.

WATER PLAY
I give permission to participate in water play within the CYP Splash Pad/Provider's yard. Water play may include sprinklers, a water hose, small containers of water, and water tables; child will need separate clothes to participate in water play. Wading pools will not be used.

Child_____ YES____ NO____ Child_____ YES_____ NO_____

_____
Parent's Signature & Date

DAILY WALKS
I give permission to go on daily walks around the base. I understand I will be notified as to the destination and time of the walks, so that I may reach my child if necessary. I also understand that a cell phone and emergency information will be taken on each field trip.

Child_____ YES____ NO____ Child_____ YES____ NO_____

_____
Parent's Signature & Date

MCCS Auto-Debit Authorization Form

MCAS Yuma, PO Box 99119, Yuma, AZ 85369

Child(ren) Full Name(s): _____

Sponsor's Full Name: _____

Please initial the below paragraphs. Your initials are consent and agreement to the following:

_____ I am authorizing MCCS MCAS Yuma Child and Youth Programs (CYP) to charge my debit (bank card)/credit card ending in __ __ __ __ (last 4 digits) that expires on __ / __ for child care fees on a weekly basis.

_____ I agree, I am responsible for any processing fees assessed by my financial institution and that MCCS will not be held responsible for any additional bank fees or processing fees resulting from any of these weekly charges.

_____ I acknowledge I am still responsible for all fees and understand that if I do not see the charges appearing on my debit bank card/credit card statement it is my responsibility to notify CYP for follow up or make other payment arrangements.

_____ I understand that it is my responsibility to update MCCS if any activity/program and debit bank card/credit card information changes occur. This includes new card numbers, name changes and expiration date. I further agree that MCCS is not responsible for reminding me to update this required information. Late payments will apply if transactions are unable to be processed.

_____ I acknowledge that the origination of my debit bank card/credit card account must comply with the provisions of U.S. law.

_____ I certify that I am an authorized user of this debit bank card/credit card and will not dispute these scheduled transactions with my debit bank card/credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE_____ DATE _____

PRIVACY ACT STATEMENT-The following information is provided to comply with the Privacy Act of 1974. All information collected on this form is required under the provisions of the Federal Financial Management Act of 1994, Section 3332 of title 31 of U.S.C. This information will be used by the MCCS to transmit payment, by electronic means to and from patron's financial institution. Failure to provide the requested information may delay or prevent the receipt of payment through the ACH Program

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Debit Bank Card/Credit Card

Cardholder Name: _____

Card Number: _____

Expiration Date: _____

CCV: _____ Card Type: _____

USMC CHILD AND YOUTH PROGRAMS HEALTH ASSESSMENT

OMB No. 0703-0068
OMB Approval Expires 09/30/2025

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); E.O. 9397 (SSN), as amended; 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: Information will be accessed by CYP personnel with a need to know to meet the purpose. Information may be disclosed to health care providers. Any release of information contained in this system of records outside of DoD will be compatible with the purposes for which the information collected and maintained. A complete list and explanation of the applicable routine uses are published in the authorizing SORN available at:https://dpcld.defense.gov/Privacy/SORNsIndex/DODwide-SORN-Article-View/Article/570428/nm01754-3/.
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 30 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.

GENERAL INFORMATION (please print) Pages 1 and 2 to be completed by Parent/Guardian

1. Sponsor Name (Last, First)	2. Sponsor Phone Number
3. Participant Name (Last, First)	
4. Date of Birth	5. Gender
6. Enrolled in Public School ◯ Yes ◯ No	

IDENTIFICATION OF CHILD/YOUTH CONDITIONS AND ACCOMMODATIONS

7. The child/youth has the following (check all that apply):

◯ **N/A - Child/Youth does not have any identified needs, considerations or accommodation requirements**

◯ **Allergies (Attach Allergy Action Plan)**

Food Environmental Medicine Type of reaction ◯ Anaphylaxis ◯ Local reaction (mild)

Other/Explain:

◯ **Asthma or Reactive Airway Disease (Attach Asthma Action Plan)**

Explain (triggers, controlled, medication required):

◯ **Behavioral or Emotional Needs (e.g., ADD, Autism, and ODD)**

Explain:

◯ **Developmental Delay or Needs**

Explain:

◯ **Diabetes (Attach Diabetes Care Plan)** ◯ Insulin dependent ◯ Non-insulin dependent

Explain:

◯ **Environmental Adaptations (e.g., room temperature and wheelchair access)**

Explain:

◯ **Needs Assistance with Activities of Daily Living**

Explain:

Participant Name (Last, First):	Date of Birth:

IDENTIFICATION OF CHILD/YOUTH CONDITIONS AND ACCOMMODATIONS *Continued*

○ **Orthopedic Condition**

Explain:

○ **Other Chronic Health Condition (e.g., bladder/bowel condition, cancer, and hemophilia)**

Explain:

○ **Seizures (Attach Seizure Action Plan)** Type of seizure: ○ Febrile ○ Absent ○ Epilepsy ○ Other Seizure Disorder

Explain:

○ **Skin conditions (e.g., rashes, eczema, discoloration, birth marks, and cloth diaper use)**

Explain:

○ **Special Diet/Food Intolerance or Dietary Modifications**

Explain:

○ **Speech/Communication Needs**

Explain:

○ **Vision/Hearing Disability**

Explain:

○ **Other (conditions/adaptations/modifications/recommendations/concerns or comments to ensure the child's/youth's needs are met)**

Explain:

8. Does your child require medication while participating in CYP? (If yes, a Medication Authorization must be completed)

○ Yes ○ No If yes, please list

9. Has the child/youth required the care of a Health Care Provider for any ongoing health conditions or surgeries in the past year? ○ Yes ○ No

If yes, explain circumstances and current status

10. Is the child/youth enrolled in Exceptional Family Member Program? ○ Yes ○ No If yes, what branch of Service?

11. Child has an ○ Individualized Family Service Plan (IFSP) ○ Individualized Education Program ○ 504 Plan ○ Behavioral Plan ○ None

If a plan is identified, what type of services does your child/youth receive (e.g. speech, physical, occupational, ABA)?

Will required services be provided by outside agencies (e.g., early intervention and school district) during care? ○ Yes ○ No

A current copy of the child/youth immunization record must be given to CYP.

PARENT/GUARDIAN SIGNATURE

I understand that all reasonable efforts will be made to support the needs documented on this health assessment. Each child's needs and required accommodations are considered on a case-by-case basis by a collaborative team at the program level. Some cases need the support of the Inclusion Action Team (IAT) to determine reasonable accommodations and identify additional resources. Parent/guardian(s) will be notified and invited to attend IAT meetings. I acknowledge that CYP is not responsible for providing the child/youth with services that would be considered skilled nursing or behavioral, occupational, speech, or physical therapy. I understand that this form must be updated annually, or earlier, if there is a change in condition or need.

12. Name (Last, First):	13. Signature:	14. Date:

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

15. Name (Last, First):	16. Signature:	17. Date:

Participant Name (Last, First):	Date of Birth:

PHYSICAL EXAMINATION (To be completed by Licensed Health Care Provider)(May attach last physical if within last 12 months)

18. Date of Physical Assessment:	19. Height:	20. Weight:	21. BP:	22. HR:

	Within Normal	Abnormal Finding	Not evaluated		Within Normal	Abnormal Finding	Not evaluated		Within Normal	Abnormal Finding	Not evaluated
23. HEENT				24. Neurological				25. Urinary			
26. Dental/Oral				27. Back/ Extremities				28. Abdomen			
29. Lungs				30. Skin				31. Heart			
32. Genital				33. Explain abnormal findings:							

34. Passed all age appropriate routine screenings: ◯ Yes ◯ No (if no, please explain **and note if referred to specialist**)

35. Immunizations are current and up to date ◯ Yes ◯ No

Medical Exemption: I certify that administration of the below vaccine(s) would be detrimental to this child's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

This contraindication is ◯ permanent ◯ or temporary and expected to preclude immunizations until: Date (M/D/YYYY):

☐ CONDITIONAL EXEMPTION: This participant has received at least one dose of each of the vaccines required and has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on:

A current copy of the child/youth immunization record must be given to CYP.

MEDICATION (If more space is needed, please attach additional documents)

36. Ongoing medications prescribed for child/youth? ◯ Yes ◯ No If Yes, list medications (including Emergency) below and indicate which require administration during child care hours.

37. Medication Name and Strength	38. Dosage	39. Frequency	40. Potential Side-Effects	41. Required during childcare
				☐
				☐
				☐
				☐
				☐
				☐

42. Carry and Self-Administer Authorization for School Age Care and Youth only (provider initials)

	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.

43. The child/youth is able to participate in CYP and appears to be free from contagious or communicable diseases. ◯ Yes ◯ No

If no, please explain:

44. Healthcare Provider Stamp or Printed Name & Address	45. Healthcare Provider Signature
	46. Date

USMC CHILD AND YOUTH PROGRAMS NON-MEDICATED TOPICAL PRODUCTS AUTHORIZATION

OMB No. 0703 - 0068

OMB approval expires 09/30/2025

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 FOR MAINTENANCE OF THE SYSTEM: 10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. 5041, Headquarters, Marine Corps; DoD Instruction 6060.02 Ch-2, Child Development Programs; DoD Instruction 6060.04, Youth Services Policy; OPNAV Instruction 1700.9E CH-1, Child and Youth Program; Marine Corps Order (MCO) 1710.30, Marine Corps Child and Youth Programs (CYP); E.O. 9397 (SSN), as amended, and SORN **NM01754-3**.

PRINCIPAL PURPOSE: Information requested is used for the purpose of managing and administering the authorization to apply Non-Medicated Topical Products to CYP participants, as applicable.

ROUTINE USES: Information will be accessed by USMC CYP authorized personnel with a need-to-know to meet the purpose. Information may be disclosed to individuals or organizations authorized to provide services to the individual client. A complete list and explanation of the applicable routine uses in published in the authorizing SORN available at: **https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570428/nm01754-3/**

DISCLOSURE: Information is voluntary; however, failure to provide information will prevent CYP from applying Non-Medicated Topical Products to participant.

RECORD MANAGEMENT: This form shall be managed in accordance with record schedule 1000-39, "Morale and Welfare Program Management" of SECNAV M-5210.1.

AGENCY DISCLOSURE NOTICE

The public reporting burden for this collection of information, **[OMB Control Number 0703-0068]** is estimated to average 10 minutes as appropriate per response, including the time for reviewing instruction, searching data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or 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.

Participant and Non-Medicated Topical Products Information

1. Participant First and Last Name:	2. Participant Date of Birth:

Topical Products

3. Please mark which non-medicated topical product you are authorizing CYP to apply:

☐ Diaper Cream/Ointment	☐ Moisturizing Lotion	☐ Lanolin
☐ Petroleum Jelly	☐ Lip Balm (non-medicated)	☐ Sunscreen (non-aerosol)
☐ Insect/Bug Repellant (non-aerosol)	☐ Other:	

4. Additional Instructions (Specify Product):

5. SAC programs only:

☐ I give permission for my child to apply the above marked non-medicated topical products to themselves. I understand that I must supply the products and that products may not be shared with other children, including siblings. This consent is a release of liability and assumption of risk that parents assume by allowing staff to supervise when their child has applied their own topical ointments.

6. I understand that CYP will administer only the Non-Medicated Topical Products named above in accordance with the manufacturer's instructions. I hereby waive any and all claims against CYP, and agree to hold CYP harmless from any and all liability, which may arise in connection with my child's use of the Non-Medicated Topical Products when properly applied as provided herein. I understand that I must supply the products, labeled with first and last name of child, and with manufacturer's label; and that products may not be shared with other children, including siblings. I authorize CYP to apply the Non-Medicated Topical Products marked on this form to the above participant.

6a. Printed Name of Parent/Guardian:	6b. Signature of Parent/Guardian:	6c. Date:
6d. Printed Name of CYP Personnel Receiving:	**6e. Signature of CYP Personnel Receiving:**	**6f. Date:**

INSTUCTIONS FOR COMPLETING NAVMC 1750/7, USMC CHILD AND YOUTH PROGRAMS (CYP) NON-MEDICATED TOPICAL PRODUCTS AUTHORIZATION

GENERAL

The NAVMC 1750/7 is completed by the parent (or legal guardian/custodian, or Agent acting pursuant to a power of attorney) of the Child and Youth Programs participant, and CYP personnel. The form authorizes CYP to apply non-medicated topical products specified by the parent, when not contrary with the manufacturer's instructions. The authorization must not be in contradiction with the manufacturer's instructions. If there are discrepancies, the product will not be applied by CYP.
CYP may not accept, store nor apply any form of Non-Medicated Topical Products without completion of this form. This form will expire on one year from the date product was received into the program. CYP does not apply expired products. Once the Non-Medicated Topical Product is discontinued it is the responsibility of the parent/guardian to remove the it from the program. Parent/guardian is responsible for periodically checking the Non-Medicated Topical Product.

Topical Product Guidelines for Parents:
DIAPER CREAMS: Any plain diaper cream without added pain relievers or medications. May not have any restrictions on age or how often it can be used. Must not contain nut products/oil.
MOISTURIZING LOTIONS/OINTMENTS: Fragrance Free is preferred, light fragrance is allowed for use. May not have added pain relievers or medications. Sunscreen and insect repellent should be approved for children (may contain DEET). Non-medicated Lip balm is accepted. ANY medicated lotions/ointment will require all forms and authorizations required for medications.
Talcum powder and Aerosol products are not used.
CYP does not administer folk or homemade remedy products. Products must be approved for human use and safe for children.

Item 1: First and Last name of CYP Participant.

Item 2: Date of birth of CYP Participant.

Item 3: Mark box next to the non-medicated topical product(s) that CYP is authorized to apply to participant.

Item 4: Provide any additional instructions for applying the marked products.

Item 5: School Age Care participants only may be given permission to apply the marked non-medicated topical products themselves with the supervision of CYP staff by marking this box.

Item 6: Self-explanatory.

Item 6a: Print name of parent or guardian completing authorization form.

Item 6b: Signature of parent or guardian completing authorization from. Required for any non-medicated topical product to be applied in CYP.

Item 6c: Provide the date authorization form is signed by parent or guardian.

Item 6d: Print name of CYP Staff receiving basic care item(s) into the program.

Item 6e: Signature of CYP Staff receiving non-medicated topical product into program. Signature indicates product(s) contains contain the manufacturer's label and the first and last name of participant.

Item 6f: Provide date non-medicated topical product(s) is received into the program.

USMC FAMILY CARE PROGRAMS CONSENT TO RELEASE INFORMATION

OMB No. 0703-0068

OMB Approval Expires 09/30/2025

Please read the Privacy Act Statement on back before completing the form.

The public reporting burden for this collection of information, OMB No. 0703-0068, is estimated to average 0.17 hours (10 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.

GENERAL INFORMATION

1. Name	2. Date of Birth

3. Agency Name, Title, and Name of Specific Staff Contact Person or Designee

4. Additional agencies who may exchange information are listed on the back ◯ Yes ◯ No

SOURCE AND TYPE OF INFORMATION

5. This authorization applies as following.

YES	NO		YES	NO	
◯	◯	Assessment Information	◯	◯	Mental Health/Psychiatric/Psychological Records and Information
◯	◯	Educational Records and Information	◯	◯	Health and Medical Records and Information

6. Other information that may be released or exchanged (please specify or enter N/A)

7. The form of information that may be exchanged (please initial)	Written	Verbal	Computerized Data

8. This information may be exchanged for the following purposes (please initial all that apply):

Service Coordination and Treatment Planning Eligibility Determination Accommodations for MFY

Other (specify)

ACKNOWLEDGEMENT

I understand this authorization and consent will remain effective for one year from date of signature unless I revoke it sooner by notifying the agencies or individuals orally or in writing. This will stop the exchange of information authorized by this document. I understand that I have the right to know the nature of the information being exchanged, and why, when, and with whom it was shared. A copy of this signed authorization and consent is valid to exchange information. If I do not sign this form, information about me or my family member will not be exchanged and I will have to make other arrangements to obtain and provide Family Care Programs personnel necessary information about me or my family member that is held by other agencies.

I am/are the (Check one): ◯ Self ◯ Parent/Legal Guardian or Custodian ◯ Agent Acting Pursuant to a Power of Attorney

Mailing Address:

Print Name:	Signature:	Date:

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); E.O. 9397 (SSN), as amended; and SORN NM01754-3.

PURPOSE: The primary purpose of this form is to obtain consent to share Information about a patron participating in a Marine Corps Family Care Programs (MFY) between MFY personnel and other designated individuals or organizations. The information exchanged will support authorized MFY services to the patron.

ROUTINE USES: Information will be accessed by MYF personnel with a need to know to meet the purpose. Information may be disclosed to the specifically authorized individuals or organizations listed on the form. Any release of information contained in this system of records will be compatible with the purposes for which the information is collected and maintained. A complete list and explanation of the applicable routine uses are published in the authorizing SORN available at:https://dpcld.defense.gov/Privacy/SORNsIndex/DODwide-SORN-Article-View/Article/570428/nm01754-3/.

DISCLOSURE: Providing information is voluntary; however, failure to complete the form will limit MFY's ability to communicate with organizations or individuals outside of DoD and may adversely affect available services.

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

MEMORANDUM:

FROM: [insert school name]

SUBJECT: Parent Acknowledgement and Consent Letter for Child and Youth Behavioral Military and Family Life Counseling Services

Dear Parents,

We take this opportunity to inform you of a valuable resource provided by the Department of Defense. Due to the unique challenges military members face and the impact they have on families, the Office of Military Community and Family Policy provides Child and Youth Behavioral Military Family Life Counselors (CYB-MFLCs). CYB-MFLCs have advanced degrees (masters or doctoral-level) in the mental health field and specialized training in child and youth development. They support the needs of children and families by partnering with parents, faculty, counselors and staff to foster healthy growth and social skill development. The well-being and safety of your child is our top priority. To ensure a comprehensive continuum of care for your child, CYB-MFLCS may work in collaboration with school or program professionals.

CYB-MFLCs address challenging behaviors and strengthen the capacity of staff, families, programs and systems to meet the needs of military children and youth by:

- Observing, participating and engaging in classroom activities
- Developing strategies for supporting positive behavior, age-appropriate behavioral interventions to enhance coping and behavioral skills in the classrooms and at home
- Meeting one-on-one or in groups, providing evidence-based prevention and intervention services
- Implementing and modeling strategies for teacher and staff responses to children's behavior
- Conducting trainings for staff
- Facilitating groups to increase parents' understanding of social emotional development and positive behavior guidance strategies
- Linking families with community resources or military family programs
- Working with military children in settings such as field trips and other center, camp, or school sponsored activities.
- Conducting individual sessions to address the unique challenges of school-aged military children and youth

At no time will the CYB-MFLC meet individually with a child without being in line of sight of a teacher, staff, or a parent/guardian. CYB-MFLCs are mandated reporters and information provided to the CYB-MFLC will be kept confidential, except to meet legal obligations or to prevent harm to self or others. Legal obligations include requirements of law and DoD or military regulations. Harm to self or others includes suicidal thought or intent, a desire to harm oneself, domestic violence, child abuse or neglect, violence against any person, and any present or future illegal activity. The CYB-MFLC is obligated to follow school and military child and youth programs'

regulations for reporting safety concerns including problematic sexual behaviors in children and youth.

CYB-MFLCs encourage the participation of parents in decisions that affect their children and strive to empower parents with the knowledge and skills to act in their children's best interest. CYB-MFLCs are flexible and can schedule appointments, meetings and activities after hours and on weekends, if needed, with advance notice. They are available to meet with individuals and families who have interest in seeking consultation about their child or family.

Thank you for allowing us to provide support services to your child/children.

Acknowledgement of Understanding:

I understand the role of the CYB-MFLC and that they may work in collaboration with school or program professionals to ensure a comprehensive continuum of services. I also understand that the CYB-MFLCs are mandated reporters as outlined above.

Please select applicable boxes below:

☐ I understand the above CYB-MFLC program description and authorize my child to participate in CYB-MFLC direct face-to-face non-medical counseling sessions. This authorization is valid for the duration of my child's enrollment and can be revoked at any time in writing.

☐ I understand the above CYB-MFLC program description and authorize my child to participate and be supported ***as a part of a formal group focused on different topic areas***. This authorization is valid for the duration of my child's enrollment and can be revoked at any time in writing.

Print Name of Child: _____

Print Name of Parent or Guardian: _____

Parent or Guardian Signature: _____

Date: _____

2025-2026 **Meal Benefit Income Eligibility Form**

Complete one application per household. Please use a pen (not a pencil).

APPLY ONLINE:
RETURN TO:
ADDRESS:

STEP 1 — List ALL children, infants, and students up to and including grade 12. Attach another sheet of paper if you need space for more names.

List ALL children in the household. Do not forget to list infants, children attending other schools, children not in school, and children not applying for benefits. This includes children not related to you in your household.

Child's First Name	MI	Child's Last Name	Age	Foster Child	Migrant	Runaway	Homeless
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐

Check all that apply

If you checked any of these boxes, please refer to the Application Instruction's Step 1: Part C & Part D.

STEP 2 — Do any household members (including you) participate in: SNAP, TANF, or FDPIR?

○ **NO** → Go to STEP 3. ○ **YES** → Write case number here and proceed to STEP 4. **CASE NUMBER (NOT EBT NUMBER):**

Write only one case number in this space.

STEP 3 — List ALL household members and income for each member (before taxes and deductions)

A. All Adult Household Members (Anyone who is living with you and shares income and expenses, even if not related, including you.)
List all Adult Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they receive income, report total gross income (before taxes and deductions) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)	Earnings from Work	How often received? Weekly	Every 2 Weeks	2x Month	Monthly	Annual	Public Assistance, Child Support, Alimony	How often received? Weekly	Every 2 Weeks	2x Month	Monthly	Pensions, Retirement, Social Security, SSI, VA Benefits, All Other	How often received? Weekly	Every 2 Weeks	2x Month	Monthly
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults)

Last Four Numbers of Social Security Number of Primary Wage Earner or other Adult Household Member (If Applicable)

Check if no Social Security Number ☐

Please see application's back for list of income sources.

B. Child Income
Sometimes children in the household earn or receive income.
Include the TOTAL income (before taxes and deductions) received by ALL children listed in STEP 1 here.

Child Income	How often received? Weekly	Every 2 Weeks	2x Month	Monthly	Annual
$	○	○	○	○	○

STEP 4 — Contact information and adult signature.

RETURN COMPLETED FORM TO Insert address here

"I certify (promise) that all information on this application is true and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (confirm) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Print Name of Adult Signing the Form | Signature of Adult | Today's Date

Mailing Address (if available) | City | State | Zip | Phone (optional) | Email (optional)

SOURCES AND EXAMPLES OF INCOME

For additional information on income, please refer to the instructions that accompany this application.

Sources of Income			Examples of Income for Children
Earnings from Work	**Public Assistance/Alimony/ Child Support**	**Pensions/Retirement/ All other sources of income**	• A child has a regular full or part-time job where they earn a salary or wages
• Salary, wages, cash bonuses, tips, commissions • Net income from self-employment (farm or business) **If you are in the U.S. Military:** • Basic pay and cash bonuses (do NOT include combat pay, FSSA, or privatized housing allowances) • Allowances for off-base housing, food, and clothing	• Unemployment benefits • Workers' compensation • Supplemental Security Income (SSI) • Cash assistance from State or local government • Alimony payments • Child support payments • Veterans benefits • Strike benefits	• Social Security/Disability (including railroad retirement and black lung benefits) • Private Pensions or disability benefits • Income from trusts or estates • Annuities • Investment income • Earned interest • Rental income • Regular cash payments from outside household	• A child is blind or disabled and receives Social Security benefits • A parent is disabled, retired, or deceased, and their child receives Social Security benefits
			• A friend or extended family member regularly gives a child spending money
			• A child receives regular income from a private pension fund, annuity, or trust

OPTIONAL

Children's ethnic and racial identities. This information is kept confidential and may be protected by the Privacy Act of 1974.

We are required to ask for information about your children's race and ethnicity. This information is important and helps to make sure we are fully serving our community. Responding to this section is optional and does not affect your children's eligibility for free or reduced price meals.

Ethnicity (check one): ☐ Hispanic or Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish Culture or origin, regardless of race) ☐ Not Hispanic or Latino

Race (check one or more): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Return this completed form to your child's school. *Do not mail, fax, or email completed applications to the U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights.

DO NOT FILL OUT

For official use only.

Annual Income Conversion: Weekly × 52, Every 2 Weeks × 26, Twice a Month × 24, Monthly × 12. Do not annualize income to determine eligibility unless more than one income frequency is listed.

Total Income — How often? Weekly ○ | Every 2 Weeks ○ | 2x Month ○ | Monthly ○ | Annual ○

Household size

Categorical Eligibility ☐

Eligibility: Free ○ | Reduced ○ | Paid ○

Eligibility For Family Day Care Homes: Tier I ○ | Tier II ○

Determining Official's Signature | Date | Confirming Official's Signature | Date | Verifying Official's Signature | Date

Use of Information Statement

The Richard B. Russell National School Lunch Act requires that we use information from this application to see who qualifies for free or reduced price meals. We can only approve complete forms. We may share your eligibility information with education, health, and nutrition programs to help them deliver program benefits to your household. Inspectors and law enforcement may also use your information to make sure that program rules are met.

Please be sure to provide the last four numbers of the Social Security number of the adult household member who signs the application. If the adult does not have one, 'Check if no Social Security Number.' Applications for a foster child do not need to list a Social Security number. Applications for children in households receiving Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) or Food Distribution Program on Indian Reservations (FDPIR) do not need to list a Social Security number. Some children qualify for free meals without an application. Please contact your school to get free meals for a foster child, and children who are homeless, migrant, or runaway.

The contact information below is solely to file a complaint of discrimination

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the State or local Agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Mail Stop 9410, Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov.

USDA is an equal opportunity provider, employer, and lender.

***Do not mail applications to this address, only complaints of discrimination.**