Family Care Branch
Child and Youth Programs
814 Radford Blvd., Suite 20311
Albany, Georgia 31704
229-639-5765

SPECIAL EVENT REGISTRATION

Branch of Service: ____
Child Name: ____ DOB: ________________
Sponsor Name: ____ Sponsor Rank: _________
Address: ____
City, State: _______________________ _____________ Zip: ___________________
Home Phone: ________________ Cell Phone: _________________
Spouse Name: ____ Cell Phone: ________________

In the event I cannot pick up my child for any reason, or in case of an emergency in which I (the parent/guardian) cannot be reached, I hereby authorize the following person(s) to pick up my child:

(1)____
(Name) (Relation to Child) (Contact Number)

(2)____
(Name) (Relation to Child) (Contact Number)

(3)____
(Name) (Relation to Child) (Contact Number)

PRIVACY ACT STATEMENT

AUTHORITY: 5 U.S.C. Sec 301

PRINCIPAL PURPOSE: The information, which will be solicited, is intended principally for the following purposes:

a. Determination of those dependents eligible to be placed into CYP services maintained by the Marine Corps Logistics Base, Albany, Georgia.
b. To provide information to CYP personnel on any health problem(s) of your child, youth or teen and to have necessary information on file to contact parents in case of emergency.
c. Other determinations, as required, in the course of naval administrations.

ROUTINE USE: In addition to being used within the Department of the Navy and Defense for the purpose(s) indicated above, the record may, as appropriate, be furnished to the U.S. Attorney for use in determinations concerning issues of liability.

DISCLOSURE: Disclosure of requested information is voluntary. However, if requested information is not provided, individuals will not be allowed to utilize CYP services.

____ ____________________________
Sponsor Signature Date

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HEALTH DATA

Does your child have any Allergies (food or other)? Please List: ____
____
Does your child have a *Special Need? Please List: ____
Any other Medical Conditions: ____
List any routine medication(s) and dosage(s) or comments regarding Special Needs:
____
____

Hospital preferred: ____

**A special need is defined as a condition requiring special medical, medically-related, or special education services. Special needs include those characterized as physical, intellectual, emotional, or psychological. Every effort will be made to provide care for children with special needs. No child who meets the basic age and eligibility requirements may, solely on the basis of disability, be excluded from programs when reasonable accommodations can be made to meet their needs. Any child with special needs requesting care will need to provide documentation of current diagnosis and treatment. An Inclusion Action Team will meet prior to enrollment to determine the best accommodations in the least restrictive environment. These meetings are designed to create a Family Service Plan, which will detail the care necessary to provide a safe and developmentally appropriate environment for the child with a special need.*

*****Please attach a current Immunization Record*****

PARENT/GUARDIAN PERMISSIONS

I, ___________________________________ the parent(s)/guardian(s) of: _______________________________________

understand and authorize certified and designated CYP representative(s) to:

- take my child/children for medical treatment in case of an emergency where the child's condition poses an imminent or reasonably foreseeable threat to his/her loss of life, serious bodily injury, or other permanent or long term serious health risk. Additionally, it may be necessary for emergency medical personnel to transport my child/children to the best available medical facility in the vicinity.

- take all reasonable efforts to immediately notify me, and as circumstances permit, prior to taking any of the above actions. My points of contact and its indicated preferred order are listed above.

____ ______________________________
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CACFP INCOME ELIGIBILITY STATEMENT

PART I: Child(ren) or Adult enrolled to receive day care

Name: (Last, First and Middle Initial)	Food Stamp, TANF, or FDPIR case number, Assistant Unit (AU), or Client ID number for children only. All the above, or SSI or Medicaid case number for Adults. Note: Do not use EBT numbers.	Head Start Participant	Foster Child

PART II: **A. Name** (List everyone in household, including foster and non-foster children)	**B: Gross income and how often it is received** Example: $100/monthly, $100/twice a month, $100/every other week, $100/weekly **1. Earnings from work before deductions**	**2. Welfare, child support, alimony**	**3. Social Security, pensions, retirement**	**4. All other income**	**C. Check if NO Income**
1.________________________	$______/____	$______/____	$______/____	$______/____	
2.________________________	$______/____	$______/____	$______/____	$______/____	
3.________________________	$______/____	$______/____	$______/____	$______/____	
4.________________________	$______/____	$______/____	$______/____	$______/____	
5.________________________	$______/____	$______/____	$______/____	$______/____	
6.________________________	$______/____	$______/____	$______/____	$______/____	
7.________________________	$______/____	$______/____	$______/____	$______/____	

PART III: ENROLLMENT INFORMATION: Children Only

My child is normally in attendance at the facility between the hours of _______ [am/pm] to _____ [am/pm] on the following days:

(Circle all that apply). Sunday Monday Tuesday Wednesday Thursday Friday Saturday

My child will normally receive the following meals while in care:

(Circle all that apply): Breakfast AM Snack Lunch PM Snack Supper Evening Snack

PART IV: Signature and Social Security Number (Adult must sign)

An adult household member must sign this form. If Part II is completed the adult signing the form must also list his or her Social Security number or mark the "I don't have a Social Security Number" box. (See Privacy Act Statement on next page).

*I certify that all information on this form is true and that **all** income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposefully give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted. This signature also acknowledges that the child (ren) listed on the form in Part I are enrolled for care.*

Signature: ____________________________________ **Print Name:**___________________________________ **Date:**________________________

Address: ____ **City:** ________________________ **State:** GA **Zip:**__________ **Phone:** ____________

Last four Digits of Social Security Number: XXX-XX___________ ☐ I do not have a Social Security Number

PART V: Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	**Mark one or more racial identities:**
Hispanic/ Latino Not Hispanic/ Latino	Asian White Black or African American American Indian or Alaska Native Native Hawaiian other Pacific Islander

Official Use Only: Annual Income Conversion: Weekly x 52, Every 2 weeks x 26, Twice a month x 24, Monthly x 12

Total income: _____________________ Per: Week Every 2 weeks Twice a month Month Year Household Size: _______

Categorical Eligibility: ______ Date withdrawn _____________ Eligibility: Free _____ Reduced _____ Paid ______ Tier I _____ Tier II ______

Temporary: Free _____ Reduced _____ Time Period: ________________________ (expires after ______days)

Determining Official's Signature: ____ Date_______________________________

Confirming Official's Signature: ____ Date_______________________________

Follow Up Official's Signature: ____ Date_______________________________

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PLEASE COMPLETE PACKAGE AND RETURN TO:

MCLB Albany Child and Youth Programs
Central Enrollment Resource and Referral
814 Radford Blvd, Suite 20311
Building 7600
Albany, GA 31704-0311
Phone: 229-639-7930 DSN 567-7930
Fax: 229-639-5096
Email: mclbarr@usmc-mccs.org

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