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: _____
Sponsor Affiliation: _____

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 **local 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 MEAL BENEFIT INCOME ELIGIBILITY STATEMENT

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

Name: (Last, First and Middle Initial)	Date of Birth (Optional) MM/DD/YYYY	SNAP, TANF, or FDPIR case number, or Client ID number for children only. All the above, or SSI or Medicaid case number for adults. **Note:** Do not use EBT numbers. Write case number and proceed to Part III.	Children in Head Start or foster care are eligible for free meals. Check (√) all that apply.	
			Head Start	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				C. Check if NO Income
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement	4. All other income	
1._____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	
2._____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	
3._____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	
4._____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	
5._____	$_____/_____	$_____/_____	$_____/_____	$_____/_____	

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:

□ **Hispanic/ Latino**

□ **Not Hispanic/ Latino**

Mark one or more racial identities:

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
Child Development Center
814 Radford Blvd, Suite 20311
Building 7600
Albany, GA 31704-0311
Phone: 229-639-5765
Fax: 229-639-6157
Email: mclbarr@usmc-mccs.org

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