HEALTH ASSESSMENT/SPORTS PHYSICAL STATEMENT (HASPS) for CYS SERVICES

ENROLLMENT, Renewal & SPORTS PHYSICAL Requirements

Revised 08Jan 09

DATA REQUIRED BY THE PRIVACY ACT OF 1994										
PRINCIPAL PURPOSE: Information is used by DA personnel to: (1) verify child health status of immunization per admission requirements; (2) note special program considerations or restriction on child participation; (3) execute emergency medical procedure for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program; (5) certify physically fit to participate in sports. ROUTINE USES: No information is disclosed outside DOD. DISCLOSURE: Information is voluntary; however, if information is not provided, individuals may not be able to participate in community activities.										
INSTRUCTIONS: All sections A, B, C. must be completed										
PART: A Medical History (Filled out by parent / guardian)										
Name of Sponsor	Home Telephor	ne		Duty/Work Telephone						
	Cell Telephone									
Sponsor Unit / Work Address	<u> </u>					Spouse's Work Telephone				
CHILD HEALTH INFORMATION										
Name of Child		n Date	ALTITUM ORWATION		Sex					
Dans variabild have a series as a disclaration					Male	Female				
Does your child have ongoing medical conce (If Yes, explain circumstances and current sta	rns? atus)									
Yes No										
Is your child enrolled in Exceptional Family M	ember Program?									
(If Yes, explain)										
☐Yes ☐ No										
165146										
		MEDI	ICAL HISTORY							
	YES	MEDI NO	ICAL HISTORY			YES	NO			
Any hospitalization or operations	YES		14. Heat stroke or exh			YES	NO			
2. Allergies to medicine, insect bites or food	YES		14. Heat stroke or exh 15. Broken bones or s	sprains		YES	NO			
 Allergies to medicine, insect bites or food Speech or development delays 	YES		14. Heat stroke or exh15. Broken bones or s16. Joint injuries (Ank	sprains le/Knee/Wrist)		YES	NO			
 Allergies to medicine, insect bites or food Speech or development delays Vision Problems (Glasses / Contacts) 	YES		14. Heat stroke or exh 15. Broken bones or s 16. Joint injuries (Ank 17. Required restricte	sprains le/Knee/Wrist)		YES	NO			
 Allergies to medicine, insect bites or food Speech or development delays Vision Problems (Glasses / Contacts) Ear or hearing problems 	YES		14. Heat stroke or exh 15. Broken bones or s 16. Joint injuries (Ank 17. Required restricte 18. Diabetes	sprains le/Knee/Wrist)	,	YES	NO			
 Allergies to medicine, insect bites or food Speech or development delays Vision Problems (Glasses / Contacts) Ear or hearing problems Seizures or Convulsions 	YES		14. Heat stroke or exh 15. Broken bones or s 16. Joint injuries (Ank 17. Required restricte 18. Diabetes 19. Cancer	sprains le/Knee/Wrist) d physical activity	,	YES	NO			
 Allergies to medicine, insect bites or food Speech or development delays Vision Problems (Glasses / Contacts) Ear or hearing problems Seizures or Convulsions Dizziness or fainting with exercise 	YES		14. Heat stroke or exh 15. Broken bones or s 16. Joint injuries (Ank 17. Required restricte 18. Diabetes 19. Cancer 20. Dental or orthodor	sprains le/Knee/Wrist) d physical activity ntic braces	,	YES	NO			
 Allergies to medicine, insect bites or food Speech or development delays Vision Problems (Glasses / Contacts) Ear or hearing problems Seizures or Convulsions Dizziness or fainting with exercise Headaches 	YES		14. Heat stroke or exh 15. Broken bones or s 16. Joint injuries (Ank 17. Required restricte 18. Diabetes 19. Cancer 20. Dental or orthodor 21. Learning problems	sprains le/Knee/Wrist) d physical activity ntic braces	,	YES	NO			
 Allergies to medicine, insect bites or food Speech or development delays Vision Problems (Glasses / Contacts) Ear or hearing problems Seizures or Convulsions Dizziness or fainting with exercise Headaches Head injury or loss of consciousness 	YES		14. Heat stroke or exh 15. Broken bones or s 16. Joint injuries (Ank 17. Required restricte 18. Diabetes 19. Cancer 20. Dental or orthodor 21. Learning problems 22. Sleep problems	sprains le/Knee/Wrist) d physical activity ntic braces	1	YES	NO			
Allergies to medicine, insect bites or food Speech or development delays Vision Problems (Glasses / Contacts) Ear or hearing problems Seizures or Convulsions Dizziness or fainting with exercise Headaches Head injury or loss of consciousness Neck or back injury	YES		14. Heat stroke or exh 15. Broken bones or s 16. Joint injuries (Ank 17. Required restricte 18. Diabetes 19. Cancer 20. Dental or orthodor 21. Learning problems 22. Sleep problems 23. Behavioral problems	sprains le/Knee/Wrist) d physical activity ntic braces	,	YES	NO			
Allergies to medicine, insect bites or food Speech or development delays Vision Problems (Glasses / Contacts) Ear or hearing problems Seizures or Convulsions Dizziness or fainting with exercise Headaches Head injury or loss of consciousness Neck or back injury Asthma or difficulty breathing	YES		14. Heat stroke or exh 15. Broken bones or s 16. Joint injuries (Ank 17. Required restricte 18. Diabetes 19. Cancer 20. Dental or orthodor 21. Learning problems 22. Sleep problems 23. Behavioral problet 24. ADD / ADHD	sprains le/Knee/Wrist) d physical activity ntic braces s	,	YES	NO			
Allergies to medicine, insect bites or food Speech or development delays Vision Problems (Glasses / Contacts) Ear or hearing problems Seizures or Convulsions Dizziness or fainting with exercise Headaches Head injury or loss of consciousness Neck or back injury Asthma or difficulty breathing	YES		14. Heat stroke or exh 15. Broken bones or s 16. Joint injuries (Ank 17. Required restricte 18. Diabetes 19. Cancer 20. Dental or orthodor 21. Learning problems 22. Sleep problems 23. Behavioral problet 24. ADD / ADHD 25. Autism Spectrum	sprains le/Knee/Wrist) d physical activity ntic braces s ms	,	YES	NO			
Allergies to medicine, insect bites or food Speech or development delays Vision Problems (Glasses / Contacts) Ear or hearing problems Seizures or Convulsions Dizziness or fainting with exercise Headaches Head injury or loss of consciousness Neck or back injury Asthma or difficulty breathing Heart or blood pressure problems Chest pain with exercise			14. Heat stroke or exh 15. Broken bones or s 16. Joint injuries (Ank 17. Required restricte 18. Diabetes 19. Cancer 20. Dental or orthodor 21. Learning problems 22. Sleep problems 23. Behavioral problet 24. ADD / ADHD	sprains le/Knee/Wrist) d physical activity ntic braces s ms	,	YES	NO			
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2. Allergies to medicine, insect bites or food 3. Speech or development delays 4. Vision Problems (Glasses / Contacts) 5. Ear or hearing problems 6. Seizures or Convulsions 7. Dizziness or fainting with exercise 8. Headaches 9. Head injury or loss of consciousness 10. Neck or back injury 11. Asthma or difficulty breathing 12. Heart or blood pressure problems 13. Chest pain with exercise If you answer yes to any of the above, please Ongoing Medications Name	e explain:	NO	14. Heat stroke or exh 15. Broken bones or s 16. Joint injuries (Ank 17. Required restricte 18. Diabetes 19. Cancer 20. Dental or orthodor 21. Learning problems 22. Sleep problems 23. Behavioral problet 24. ADD / ADHD 25. Autism Spectrum	sprains le/Knee/Wrist) d physical activity ntic braces s ms Disorder below)		YES	NO			

DADT B. Dhysical Evam									
PART B: Physical Exam	Parameter of Constant	and a strain of the second	D	D	Describing on ND. Disprinted a Applicant DAX				
	by licensed independent practitioner: Doctor-Dr., Nurse			Dr., Nurse					
Age	Height				Weight				
YRS MOS	cm. (%ile)				kgs. (%ile)				
BP: / P:	Visual Acuity Right / Left /			1	Tootod with / without aloogo				
1.	ŭ			,	Tested with / without glasses				
	NORMAL	ABNORMAL	N/A	COMME	NTS				
1. Eyes									
2. Ears, Nose & Throat									
3. Hearing									
4. Mouth & Teeth									
Neck (Soft tissues)									
6. Cardiovascular									
7. Chest & Lungs									
8. Abdomen									
9. Genitalia – Hernia									
10. Skin & Lymphatics									
11. Spine – Scoliosis									
12. Extremities									
13. Neurological									
14. Wears braces / plates									
Based on this HX and PX exam, the follow	owing abnormali	ties were found ar	nd may ne	ed treatme	nt:				
Immunizations are current and up to dat	e: L Yes	□ No							
	PAF	RTICIPATION	RECOM	IMENDA	TIONS				
All sportsYes No									
			. , , ,	,	3				
Additional comments:		☐ Res	trictions:						
	Sports Phy	ysical is valid for	1 year fro	om date in	dicated below				
PART C									
	cribe any enecia	l program needs	considera	tions or ros	strictions which the child requires in order to participate in				
CYS programs (to include Sports).	clibe ally specia	ii piogram needs,	Considera	uons or res	strictions which the child requires in order to participate in				
o ro programs (to include oports).									
Child / Youth is able to participate in nor	mal CYS progra	ms? Y	es	☐ No					
Date Licensed Health Care Professional Stamp Licensed Health Care Professional; Dr., NP or PA Signature									
Initial Date Typ	e or print name	of Parent or Gu	ardian		Signature of Parent or Guardian				
,,,					3				
HASPS Renewal (Not Part of the Sports Physical)									
Year 2 Date Hea	Ith Status Cha			то орог	Signature of Parent or Guardian				
Teal 2 Date	itii Status Ciia	iigeu			Signature of Farent of Guardian				
☐ Yes	☐ No								
Year 3 Date Hea	alth Status Cha	inged			Signature of Parent or Guardian				
	-	-							
☐ Yes	∐ No								