## HEALTH ASSESSMENT/SPORTS PHYSICAL STATEMENT (HASPS) for CYS SERVICES ENROLLMENT, Renewal & SPORTS PHYSICAL Requirements

Revised 08 lan 09

DATA REQUIRED BY THE PRIVACY ACT OF 1994										
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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. mus	t be completed		,							
PART: A Medical History (Filled out by parent / guardian)										
Name of Sponsor	Home Telephone		Duty/Work Telepho	ne						
Sponsor Unit / Work Address	Cell Telephone	17	Spouse's Work Tele	ophone						
L CONTROL OF THE PROPERTY OF T			Spouse a Work Tek	ерпопе						
CHILD HEALTH INFORMATION										
Name of Child	Birth Date		Sex							
		•		· 						
Dana your shild have angoing modical concer			Male	Female						
Does your child have ongoing medical concer (If Yes, explain circumstances and current sta				•						
			•							
Yes No		<u> </u>								
ls your child enrolled in Exceptional Family Member Program? (If Yes, explain)										
Yes No										
MEDICAL LISTORY										
	ME	DICAL HISTORY	,							
		DICAL HISTORY		VES NO						
Any hospitalization or operations	YES NO		on	YES NO						
Any hospitalization or operations     Allergies to medicine, insect bites or food		14. Heat stroke or exhausting 15. Broken bones or sprain.		YES NO						
		14. Heat stroke or exhaustic	S	YES NO						
2. Allergies to medicine, insect bites or food		14. Heat stroke or exhausti	s ee/Wrist)	YES NO						
<ol> <li>Allergies to medicine, insect bites or food</li> <li>Speech or development delays</li> </ol>		14. Heat stroke or exhausti 15. Broken bones or sprain 16. Joint injuries (Ankle/Kna	s ee/Wrist)	YES NO						
<ol> <li>Allergies to medicine, insect bites or food</li> <li>Speech or development delays</li> <li>Vision Problems (Glasses / Contacts)</li> </ol>		14. Heat stroke or exhausting 15. Broken bones or spraing 16. Joint injuries (Ankle/Kne 17. Required restricted physics)	s ee/Wrist)	YES NO						
<ol> <li>Allergies to medicine, insect bites or food</li> <li>Speech or development delays</li> <li>Vision Problems (Glasses / Contacts)</li> <li>Ear or hearing problems</li> </ol>		14. Heat stroke or exhaustion 15. Broken bones or sprain 16. Joint injuries (Ankle/Kne 17. Required restricted physics) 18. Diabetes	s ee/Wrist) sical activity	YES NO						
<ol> <li>Allergies to medicine, insect bites or food</li> <li>Speech or development delays</li> <li>Vision Problems (Glasses / Contacts)</li> <li>Ear or hearing problems</li> <li>Seizures or Convulsions</li> </ol>		14. Heat stroke or exhaustion 15. Broken bones or sprain 16. Joint injuries (Ankle/Knet 17. Required restricted physics) 18. Diabetes 19. Cancer	s ee/Wrist) sical activity	YES NO						
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		<u> </u>			
PART B: Physical Exam					
Modical Staff Assessment (Completed b	v licensed inden	endent practitions	er: Doctor-	Or Nurse P	ractitioner-NP, Physician's Assistant-PA)
	Height	Chacht practition	or. Doctor		Weight
Age YRS MOS		cm. (	%ile)		kgs. (%ile)
BP: /	Visual Acuity				
P:	Right / Left / Tested with / without glasses			Tested with / without glasses	
	NORMAL	ABNORMAL	N/A	COMMEN	ITE
	NURWAL	ABNURWAL	N/A	COMMEN	(13
1. Eyes			ļ	·	
2. Ears, Nose & Throat			<u> </u>	<u> </u>	
3. Hearing			<del>                                     </del>	1	
4. Mouth & Teeth			ļ		
5. Neck (Soft tissues)				<b>}</b>	
6. Cardiovascular	<b>_</b>		<del> </del>	1	
7. Chest & Lungs				<del> </del>	
8. Abdomen			ļ	ļ	
9. Genitalia – Hernia			1	<u> </u>	
10. Skin & Lymphatics			ļ		
11. Spine – Scoliosis			<del></del>		
12. Extremities			<u> </u>	ļ	
13. Neurological		·	ļ	ļ	
14. Wears braces / plates			<u></u>	1	
Based on this HX and PX exam, the following	owing abnormali	ties were found a	nd may ne	ed treatmen	t:
	$\Box$	$\Box$ .		*	
Immunizations are current and up to dat	te: L Yes	L No.	······		
	PAR	RTICIPATION	RECOM	IMENDAT	TIONS
All sportsYes No	•	L No	mal physic	cal activity to	including PE
	•				
Additional comments:		Res	strictions:		
•	Sports Phy	sical is valid for	· 1 year fro	om date ind	icated below
			-		
PART C					
			id	tions or root	sistings which the child requires in order to participate in
	scribe any specia	ıı program needs,	considera	tions or rest	rictions which the child requires in order to participate in
CYS programs (to include Sports),				•	
				•	
Child / Youth is able to participate in nor	rmal CVS progra	me?	'es	No	
Cilila / Toditi is able to participate in noi	mai O i O progra		00		
Date Licensed Health Care	Professional St	amn	Licens	ed Health	Care Professional: Dr., NP or PA Signature
Date Licensed Health Care	riolessional Si	ranth	LICEIII	seu meann	Oale i folessional, br., ki of i A olynacio
*					* *
Initial Data	a ar print name	of Parent or Gu	ordian		Signature of Parent or Guardian
Initial Date Typ	e or hunr name	or ratem or Gu	aiulail		orginature of a drent of Guardian
*					
			D		- Dharing!\
		Renewal (Not	Part of 1	ne Sport	
Year 2 Date Hea	alth Status Cha	nged			Signature of Parent or Guardian
Yes	☐ No				
Year 3 Date He	alth Status Cha	ınged			Signature of Parent or Guardian
•					
l □ u ·					
☐ Yes	L No				