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 Telephone                  Duty/Work Telephone
                                    Cell Telephone
Sponsor Unit / Work Address       Sponsor SSN                    Spouse’s Work Telephone

CHILD HEALTH INFORMATION

Name of Child                  Birth Date                  Sex
                                  Male  Female

Does your child have ongoing medical concerns? (If Yes, explain circumstances and current status)

☐ Yes  ☐ No

Is your child enrolled in Exceptional Family Member Program? (If Yes, explain)

☐ Yes  ☐ No

MEDICAL HISTORY

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>1.</td>
<td>Any hospitalization or operations</td>
<td>14.</td>
<td>Heat stroke or exhaustion</td>
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<tr>
<td>2.</td>
<td>Allergies to medicine, insect bites or food</td>
<td>15.</td>
<td>Broken bones or sprains</td>
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<td>3.</td>
<td>Speech or development delays</td>
<td>16.</td>
<td>Joint injuries (Ankle/Knee/Wrist)</td>
<td></td>
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<td>4.</td>
<td>Vision Problems (Glasses / Contacts)</td>
<td>17.</td>
<td>Required restricted physical activity</td>
<td></td>
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<td>5.</td>
<td>Ear or hearing problems</td>
<td>18.</td>
<td>Diabetes</td>
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<td>7.</td>
<td>Dizziness or fainting with exercise</td>
<td>20.</td>
<td>Dental or orthodontic braces</td>
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<td>9.</td>
<td>Head injury or loss of consciousness</td>
<td>22.</td>
<td>Sleep problems</td>
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<td>10.</td>
<td>Neck or back injury</td>
<td>23.</td>
<td>Behavioral problems</td>
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<td>11.</td>
<td>Asthma or difficulty breathing</td>
<td>24.</td>
<td>ADD / ADHD</td>
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<td>12.</td>
<td>Heart or blood pressure problems</td>
<td>25.</td>
<td>Autism Spectrum Disorder</td>
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<td>13.</td>
<td>Chest pain with exercise</td>
<td>26.</td>
<td>Other (please list below)</td>
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If you answer yes to any of the above, please explain:

Ongoing Medications

Name                  Dosage                  Frequency

Allergies – All Types (Foods, Medicines and Insect Bites)

Type                  Reaction
PART B: Physical Exam
Medical Staff Assessment (Completed by licensed independent practitioner: Doctor-Dr., Nurse Practitioner-NP, Physician’s Assistant-PA)

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<tr>
<th>Age</th>
<th>Height</th>
<th>Weight</th>
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<tbody>
<tr>
<td>YRS</td>
<td>cm. (_____ %ile)</td>
<td>kgs. (_____ %ile)</td>
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<th>BP:</th>
<th>P:</th>
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Visual Acuity
Right / Left
Tested with / without glasses

NORMAL ABNORMAL N / A COMMENTS

1. Eyes
2. Ears, Nose & Throat
3. Hearing
4. Mouth & Teeth
5. Neck (Soft tissues)
6. Cardiovascular
7. Chest & Lungs
8. Abdomen
9. Genitilia – Hernia
10. Skin & Lymphatics
11. Spine – Scoliosis
12. Extremities
13. Neurological
14. Wears braces / plates

Based on this HX and PX exam, the following abnormalities were found and may need treatment:

Immunizations are current and up to date: ☐ Yes ☐ No

PARTICIPATION RECOMMENDATIONS

☐ All sports _____Yes _____ No ☐ Normal physical activity to including PE
☐ Additional comments: ☐ Restrictions:

Sports Physical is valid for 1 year from date indicated below

PART C
Special Medical Considerations: Describe any special program needs, considerations or restrictions which the child requires in order to participate in CYS programs (to include Sports).

Child / Youth is able to participate in normal CYS programs? ☐ Yes ☐ No

Date Licensed Health Care Professional Stamp Licensed Health Care Professional; Dr., NP or PA Signature

Initial Date Type or print name of Parent or Guardian Signature of Parent or Guardian

HASPS Renewal (Not Part of the Sports Physical)

Year 2 Date Health Status Changed Signature of Parent or Guardian
☐ Yes ☐ No

Year 3 Date Health Status Changed Signature of Parent or Guardian
☐ Yes ☐ No