

**DEPARTMENT OF DEFENSE CHILD DEVELOPMENT PROGRAM  
REQUEST FOR CARE RECORD**

**PRIVACY ACT STATEMENT**

**AUTHORITY:** PL 101-89 Sec. 1507; EO 9397.

**ROUTINE USE(S):** None.

**PRINCIPAL PURPOSE(S):** To collect applicant information for Child Development Programs and place applicants on waiting lists for program services. Information compiled from applications is also used to assist management determination of effectiveness of present and projection of future program requirements.

**DISCLOSURE:** Voluntary; however, failure to furnish requested information will result in an incomplete request for care record and possible loss of placement on Child Development Program waiting lists.

<b>1. DATE OF REQUEST (YYYYMMDD)</b>	<b>2. EXPIRATION DATE (YYYYMMDD)</b>
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**3. FAMILY INFORMATION**

<b>a. SPONSOR'S NAME (Last, First, Middle Initial)</b>	<b>b. SPOUSE'S NAME (Last, First, Middle Initial)</b>	
<b>c. CHILD'S NAME (Last, First, Middle Initial)</b>	<b>d. CHILD'S DATE OF BIRTH (YYYYMMDD)</b>	<b>e. CHILD'S AGE</b>
<b>f. HOME ADDRESS (Street, City, State, Zip Code)</b>	<b>g. SPONSOR'S BRANCH OF SERVICE</b>	
	<b>h. DUTY ORGANIZATION</b>	
<b>i. HOME TELEPHONE NUMBER (Include Area Code)</b>	<b>j. DUTY TELEPHONE NUMBER (Include Area Code)</b>	

**k. SIBLING CARE (Complete a separate form and list name and date of birth for each child requiring care)**

<b>(1) NAME (Last, First, Middle Initial)</b>	<b>(2) DATE OF BIRTH (YYYYMMDD)</b>	<b>(1) NAME (Last, First, Middle Initial)</b>	<b>(2) DATE OF BIRTH (YYYYMMDD)</b>

**4. PROGRAM(S) DESIRED (X as applicable)**      **5. AGE GROUP (X one)**

<b>a. FULL-DAY CARE</b>	<b>e. FAMILY DAY CARE (FDC)</b>	<b>a. INFANTS (0 - 12 months)</b>
<b>b. PART-DAY CARE</b>	<b>f. PART-DAY ENRICHMENT</b>	<b>b. TODDLERS (13 - 35 months)</b>
<b>c. SCHOOL-AGE</b>	<b>g. DAY CAMP</b>	<b>c. PRESCHOOL (3 - 5 years)</b>
<b>d. SPECIAL NEEDS</b>		<b>d. SCHOOL AGE (5+ years)</b>

**6. SPONSOR STATUS (X one)**

<b>a. SINGLE MILITARY</b>	<b>e. SINGLE DOD CIVILIAN</b>	<b>i. MILITARY/UNEMPLOYED SPOUSE</b>
<b>b. DUAL MILITARY</b>	<b>f. RETIRED MILITARY</b>	<b>j. MILITARY/OTHER THAN DOD SPOUSE</b>
<b>c. MILITARY/DOD SPOUSE</b>	<b>g. MILITARY RESERVE</b>	<b>k. OTHER (Specify)</b>
<b>d. DUAL DOD CIVILIANS</b>	<b>h. NATIONAL GUARD</b>	

**7. PRESENT CHILD CARE ARRANGEMENTS (X as applicable)**

<b>a. FDC ON-INSTALLATION</b>	<b>d. CIVILIAN CDC</b>	<b>g. IN-HOME CARE</b>
<b>b. FDC OFF-INSTALLATION</b>	<b>e. MILITARY ALTERNATE CARE</b>	<b>h. NO PRESENT CARE</b>
<b>c. OTHER MILITARY CHILD DEVELOPMENT CENTER (CDC)</b>	<b>f. NON-MILITARY ALTERNATE CARE</b>	<b>i. OTHER (Specify)</b>

**8. GENERAL INFORMATION (X and complete as applicable)**

<b>YES</b>	<b>NO</b>	<b>a. IF CHILD IS NOT PRESENTLY IN CARE, IS EMPLOYMENT OF SPOUSE AWAITED? (If Yes, estimate average annual income lost)</b>	<b>YES</b>	<b>NO</b>	<b>c. IS CHILD ON OTHER MILITARY WAITING LIST? (If Yes, name installation)</b>
		<b>b. HAS CHILD BEEN IDENTIFIED FOR SPECIAL NEEDS CARE?</b>	<b>d. CURRENT COST OF CARE PER WEEK (If child is currently in care)</b>		

**9. UPDATE REQUIRED PER INSTRUCTIONS (For Office Use Only)**

	(1)	(2)	(3)	(4)	(5)
<b>a. DATE CALLED (YYYYMMDD)</b>					
<b>b. DECLINED/ PLACED</b>					
<b>c. COMMENTS/ INITIALS</b>					
<b>d. PLACEMENT TIME (in months)</b>					

**FAMILY MEMBER PROGRAMS FLIGHT  
Screening Form**

This form must be completed with DD Form 2606 by all parents seeking care for their child in any of the activities of the Family Member Programs Flight –Child Development Centers, Family Child Care Program, or School-Age Programs.

Please review the following list. If your child has been identified as having one of these conditions, write “yes” on the line provided.

- ADHD (Attention deficit Hyperactivity Disorder) \_\_\_\_\_
- Asthma \_\_\_\_\_
- Autism \_\_\_\_\_
- Behavior Disorder (Specify) \_\_\_\_\_
- Breathing Difficulties \_\_\_\_\_
- Development Delay \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Food Allergies \_\_\_\_\_
- Hearing Impairment \_\_\_\_\_
- Heart Monitor \_\_\_\_\_
- Lead Poisoning \_\_\_\_\_
- Learning Disability \_\_\_\_\_
- Physical Impairment (Specify) \_\_\_\_\_
- Seizures \_\_\_\_\_
- Speech/Language Disorder \_\_\_\_\_
- Vision Impairment \_\_\_\_\_
- Other Allergies (Specify) \_\_\_\_\_
- Other Medical or Mental Conditions (Specify) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Parent/Guardian's Name

\_\_\_\_\_  
Date

**SCREENING FORM**  
To be completed with DD Form 2606 by parent/guardian and resource/referral staff.  
If individual or special need identified, proceed to Form B.