



# MOODY YOUTH SPORTS PROGRAM

## Recreational Sports Registration

**\*\*Ensure all items are completed before registration is submitted\*\***

CHILD'S NAME: \_\_\_\_\_

AGE: \_\_\_\_\_

SELECT SPORTS PROGRAM:

START SMART [AGE 3 - 5]:  BASKETBALL  SOCCER

YOUTH SPORTS [AGES 5 & UP]:  **SOCCER**

OTHER SPORTS/SPORTS CAMP: \_\_\_\_\_

SPORTS REGISTRATION FORM:

- Selected sports program
- Practice request dates indicated (Optional)
- Team/Coach request indicated (Optional)
- Shirt size indicated

COMPLETED FORM 88 (Air Force Youth Programs Registration)

Emergency contact MUST be someone other than parents/primary guardian.

SIGNED PARENT CODE OF ETHICS

**COMPLETED** DIVISION OF FAMILY & CHILD SERVICES (DFCS) PACKET

Must be completed in its entirety before registration - **After school program enrollment not required**

SPORTS PHYSICAL & IMMUNIZATIONS (must be current to participate)

Sports Physicals and Immunizations **including flu vaccination** are good for one calendar year.  
[i.e. If physical date is January 15, 2016, it will expire January 15, 2017]

Sports Physical and Immunizations are due at time of registration - **NO EXCEPTIONS!**

Date of physical (DD/MM/YY): \_\_\_\_\_

PAYMENT (waived if parent is coaching)

If coaching (must get prior Approval from Youth Sports Director):

Coach's Name \_\_\_\_\_

Coach's Packet (must be completed prior to registration)

Staff Initial \_\_\_\_\_ Date \_\_\_\_\_

PRIMARY **PERSON TO CONTACT (circle one)**: Sponsor | Spouse | **Guardian**

Name **and Number**: \_\_\_\_\_

VALID EMAIL ADDRESS (Primary form of communication)

Email address: \_\_\_\_\_

\*Additional Email(s):

\_\_\_\_\_

\*Special Requests:

\_\_\_\_\_

\_\_\_\_\_

Program Staff: Ensure that all items can be verified. Do not accept Sports Registration Packet unless it is filled out in its entirety with all required documentation - **NO EXCEPTIONS!**

YP Staff's Name: \_\_\_\_\_ YP Staff Initial: \_\_\_\_\_ Date: \_\_\_\_\_



# MOODY AFB YOUTH PROGRAMS

## Sports Registration Form

**FOR OFFICIAL USE ONLY:**

Amount Paid: \_\_\_\_\_  
 Credit Card/Debit     Cash     Check #: \_\_\_\_\_  
 Date: \_\_\_\_\_    Staff Initial: \_\_\_\_\_    Receipt#: \_\_\_\_\_

**\*\*Payment and Current Physical are due at time of registration - NO EXCEPTIONS!\*\***

**PLEASE PRINT CLEARLY**

<b>Child's Name: (Last Name, First Name)</b>	<b>Sponsor's (Parent/Guardian) Name: (Last Name, First Name)</b>
<b>Sports Program: (Please check one)</b> • Youth Sports (Ages 5 & Up) <input type="checkbox"/> Soccer • Start Smart (Ages 3&4) <input type="checkbox"/> Soccer <input type="checkbox"/> Basketball <input type="checkbox"/> Baseball • Sports Camp/Other Sports: _____	<b>Requested Practice Day &amp; Time: (Please rank preference 1 through 6)</b>  ___ Mon: 5pm    ___ Tue: 5pm    ___ Thu: 5pm ___ Mon: 6pm    ___ Tue: 6pm    ___ Thu: 6pm  <b>Requested Team/Coach: (if applicable)</b> _____
<b>Shirt Size: (Please circle one)</b>  YXS (2-4)    YS (4-6)    YM (8-10)    YL (12-14)    AS    AM    AL	<b>Physical Date: (Must remain current until the end of the season)</b>  ___/___/___ (DD/MMM/YY) (Example: 10/MAR/05) <b>Physicals are good for one calendar after the date of physical.</b>

**\*\*\*The Youth Sports Program encourages parental support to succeed. Please check below if you wish to volunteer.\*\*\***

Coach     Asst. Coach     Team Parent     Referee/Game Official     Field maintenance     Not Interested

**THE FOLLOWING STATEMENTS ARE IMPORTANT PROGRAM REQUIREMENTS/INFORMATION ITEMS. INITIAL ON THE LINE TO THE LEFT OF EACH ITEM TO INDICATE THAT YOU HAVE READ AND UNDERSTOOD EACH STATEMENT.**

\_\_\_ **1. SPORTS PHYSICAL:** A current physical is REQUIRED before the first practice of the sport season. The physical must remain current until the end of the season and are good for one calendar year (i.e. if the date of the physical is January 15, 2015, it will expire January 15, 2016).

**\*\*YOUTH WILL NOT BE ALLOWED TO PARTICIPATE IN PRATICES OR GAMES WITHOUT A CURRENT PHYSICAL ON FILE!\*\***

\_\_\_ **2. PRACTICE/TEAM/COACH REQUESTS:** Every effort will be made to honor each participant's first practice request and any team and coach requests. However, Moody Youth Sports Program cannot and does not guarantee specific practice days, team, or coach assignments. The only exception is youth playing on a team their parent is coaching, if age-appropriate.

\_\_\_ **3. PARENTAL SUPERVISION:** All children under the age of 9 years old **MUST** have a parent/guardian or sibling (over the age of 16 years old) accompany them to all practices and games. **\*\*CHILDREN AGES 8 & UNDER CANNOT BE LEFT UNATTENDED AT ANY TIME.\*\***

\_\_\_ **4. VOLUNTEER COACHES:** All Youth Sports Program coaches are volunteers and trained in accordance with AFMAN-34-804, AFI-34-144 and National Alliance for Youth Sports (NAYS) guidelines. Background checks are performed on all coaches prior to the start of the season. We ask that all parents be patient and cooperative with coaches.

\_\_\_ **5. FEES AND REFUNDS:** Fees cover uniform jerseys/shirts, sports equipment, official's fees, league administration fees, and field/facility maintenance fees. Refunds will on be given for PCS Orders/Deployment [with supporting documentation] and only if approved by the Youth Sports Director and Youth Director.

\_\_\_ **6. PARENT'S CODE OF ETHICS PLEDGE:** All parents are required to sign the parent's code of ethic pledge (PCOE), which provides expectations of parent's during the sports season. The PCOE is attached to the registration packet. Adverse behavior on the part of parents or their child(ren) may result in the suspension of privileges from this program.

\_\_\_ **15. ELECTRONIC AND PRINT PUBLICITY PERMISSION:** I give consent for my child to be photographed and those photographs to be used for educational and marketing purposes at the Moody AFB Youth Center. I also give permission for my child's photo to appear in local and base papers, on the Moody AFB/Youth Center web page, on the Youth Programs and the 23rd FSS' social media pages, on publicity displays throughout the installation and the youth center, used in other marketing and advertisements for Moody AFB Youth Programs and its various programs. Additionally, permission is granted to allow my child to be filmed and/or videotaped and have that footage featured on (those approved by military public affairs) news channels and other video marketing regarding the youth center and Moody AFB Youth Programs.

\_\_\_ **12. LIABILITY WAIVER/MEDICAL RELEASE:** I desire for my child to participate in the sports programming to be offered by the Moody AFB Youth Sports Program, and be supervised by a volunteer coach and/or paid program staff members. I am allowing my child to participate in this sports program entirely upon my own initiative, risk and responsibility. I realize the risk of physical injury to my child as a result of his or her participation in this type of activity and have instructed my child to exercise caution for him or herself as well as for the other players, volunteers, parents, coaches, and staff. By giving permission for my child to participate in the sports programming, I release all liability from the individual coach, Moody AFB Youth (Sports) Programs, 23 FSS Squadron, Moody AFB, and the U.S. Government. I understand that none of the aforementioned parties can be held liable for any accident, injury, or death that may arise from any foreseen or unforeseen circumstances. By executing this release, I will assume complete responsibility for my child's actions or incidents occurring to him or her while involved in this activity. This release in no way limits or restricts medical care for those who are so entitled.

<b>Sponsor's (Parent/Guardian) Signature:</b>	<b>Date:</b>
<b>Youth Center Staff Signature:</b>	<b>Date:</b>

**WAIVER/RELEASE FOR COMMUNICABLE DISEASES INCLUDING COVID-19**

**ASSUMPTION OF RISK / WAIVER OF LIABILITY / INDEMNIFICATION AGREEMENT**

In consideration of being allowed to participate on behalf of *Moody AFB Youth Programs* and its sports/instructional program and related events and activities, the undersigned acknowledges, appreciates, and agrees that:

1. Participation includes possible exposure to and illness from infectious diseases including but not limited to MRSA, influenza, and COVID-19. While particular rules and personal discipline may reduce this risk, the risk of serious illness and death does exist; and,
2. I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS, both known and unknown, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES or others, and assume full responsibility for my participation; and,
3. I willingly agree to comply with the stated and customary terms and conditions for participation as regards protection against infectious diseases. If, however, I observe and any unusual or significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest official immediately; and,
4. I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, HEREBY RELEASE AND HOLD HARMLESS *Moody AFB Youth Programs* their officers, officials, agents, and/or employees, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the event ("RELEASEES"), WITH RESPECT TO ANY AND ALL ILLNESS, DISABILITY, DEATH, or loss or damage to person or property, WHETHER ARISING FROM THE NEGLIGENCE OF RELEASEES OR OTHERWISE, to the fullest extent permitted by law.

**I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IF FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.**

Name of Child: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date signed: \_\_\_\_\_

## AIR FORCE YOUTH PROGRAMS REGISTRATION

### PRIVACY ACT STATEMENT

**AUTHORITY:** Title 10 U.S.C. 8012 and 44 U.S.C. 3101.

**PRINCIPLE PURPOSES:** To register dependent youth of military, retired and DoD personnel in the Air Force Youth Programs. Providing Youth Programs the authorization for medical treatment in emergency situations; authorization for transportation; record youth/family information; photo use authorization; and releasing of liability.

**ROUTINE USES:** This form may be disclosed to any DoD component or part thereof, and upon request to other Federal, State and local government agencies in the pursuit of their official duties; disclosed to news media; used for other lawful purposes including law enforcement and litigation.

**DISCLOSURE IS VOLUNTARY:** Failure to provide the information may preclude the individual from participation in Air Force sponsored youth programs.

<b>YOUTH NAME</b> <small>LAST, FIRST, MI</small>	<b>SPONSOR NAME / RANK</b> <small>LAST, FIRST</small>	<b>SPOUSE NAME / RANK</b> <small>LAST, FIRST</small>	<b>EMERGENCY CONTACT</b> <small>OTHER THAN PARENT</small>
<b>BIRTHDATE / AGE</b>	<b>ORGANIZATION</b>	<b>HOME ADDRESS</b>	<b>EMERGENCY PHONE</b> <small>SAME AS CONTACT</small>
<b>MALE / FEMALE</b>	<b>WORK PHONE</b>	<b>WORK PHONE</b>	<b>PHOTO PERMISSION</b> <small>YES / NO</small>
<b>YOUTH HOME EMAIL</b>	<b>CELL PHONE</b>	<b>CELL PHONE</b>	<b>SPONSOR WORK EMAIL</b>
<b>HOBBIES &amp; INTERESTS</b>	<b>SPONSOR SS #</b> <small>(LAST 4)</small>	<b>HOME PHONE</b>	<b>PARENT VOLUNTEER</b> <small>YES / NO</small>

**SPECIAL NEEDS CARE / ILLNESS / ALLERGIES / INJURIES**

### RELEASE OF LIABILITY AND AGREEMENTS

**MEDICAL CARE AUTHORIZATION:** I hereby authorize my child to receive emergency medical treatment whenever it is deemed necessary at any U.S. Military Facility or any other medical facility when a U.S. Military Medical Facility is not available.

**HOLD AND SAVE HARMLESS AGREEMENT:** Now therefore, in consideration of mutual covenants and agreements between the parties here to it is agreed as follows: We the parents of the above named youth agree to save and hold harmless as well as defend the Base Youth Programs, Services Division's Central Base Fund, Department of the Air Force and the contractor from and against any and all claims, demands, actions, debts, liabilities and attorney's fees. Parent further agrees to save and hold harmless the contractor and all other parties involved from and on account of damages of any kind which the youth may suffer as a result of the acts of participating in the program.

**TRANSPORTATION/FIELD TRIP:** I give Youth Programs permission to transport the aboved named youth to and from any events that I am notified of in advance.

<b>SIGNATURE OF PARENT/LEGAL GUARDIAN</b>	<b>DATE</b>
---	-------------

### FOR USE BY YOUTH PROGRAM STAFF (COMPLETE & INITIAL)

<b>PROGRAM ORIENTATION DATE</b>	<b>MEMBERSHIP CARD ISSUE DATE</b>	<b>MEMBERSHIP CARD NUMBER</b>
<b>EXPIRATION DATE</b>	<b>MEMBERSHIP FEE PAID</b>	<b>STAFF INITIAL / DATE</b>



# PARENT'S CODE OF ETHICS PLEDGE

**I hereby pledge to provide positive support, care, and encouragement for my child participating in youth sports by following the Parent's Code of Ethics:**

- A.** I will encourage good sportsmanship by demonstrating positive support for all players, coaches, and officials at every game, practice, or youth sports event.
- B.** I will place the emotional and physical well-being of my child ahead of any person desire to win.
- C.** I will provide support for coaches and officials working with my child to provide a positive, enjoyable experience for all.
- D.** I will demand a drug, alcohol, and tobacco free sports environment for my child and agree to assist from refraining from their use at all youth sports events.
- E.** I will remember that the game is for children and not adults.
- F.** I will do my very best to make youth sports fun for my child.
- G.** I will ask my child to treat other players, coaches, fans, and officials with respect regardless of race, sex, creed, or ability.
- H.** I will promise to help my child enjoy the youth sports experience within my personal constraints, by assisting with coaching, being a respectful fan, providing transportation, or whatever I am capable of doing.
- I.** I will require that my child's coach be trained in the responsibilities of being a youth sports coach and that the coach agrees to the youth sports Coach's Code of Ethics.
- J.** I will read the NYSCA National Standards of Youth Sports and do everything in my power to assist all youth sports organizations to implement and enforce them.

**I also agree that if I fail to abide by the aforementioned rules and guidelines, I will be subject to disciplinary action that could include, but not limited to the following:**

- A.** Verbal warning by official, head coach, and/or Youth Sports Director/Youth Director.
- B.** Written Warning.
- C.** Parental game suspension with written documentation of incident kept on file by Moody AFB Youth Programs.
- D.** Parental season suspension.

**Parent's Name:** \_\_\_\_\_

**Parent's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**In reference to the attached Boys & Girls Club of America (BGCA) Department of Human Services (DHS) Grant Application that follows:**

**Moody Youth Programs is a member of the Boys & Girls Club of America (BGCA) Georgia Alliance.**

**The attached paperwork is a MANDATORY component of our grant partnership. Grant funds are used by Moody Youth Programs to purchase materials and supplies for our programming (sports & instructional, School Age, and Open Recreation) to help cover staff payroll expenses, keep program costs low to patrons, and support programming costs and efforts. Your child does not have to be enrolled in a before/after school care program to complete this form.**



**Georgia Division of Family and Children Services  
Afterschool Care Program  
Youth Participation Eligibility Form**

**Page 1 of 3 - DFCS Afterschool Care Program Eligibility Form**

**(DFCS funded Agency Name)**, and the Georgia Division of Family and Children Services (DFCS) are partnering to provide valuable out-of-school programs for youth in Georgia. The information provided on this form will help ensure that eligible youth are benefiting from the partnership. **Please complete this form in its entirety and return it to the identified staff person at the program site. We thank you for your cooperation.**

**Form to be completed by Parent/Custodian/Caregiver**

**Youth Information – This section must be completed in its entirety.**

Name of Youth Participant (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Gender: \_\_\_\_\_ Male \_\_\_\_\_ Female

Date of Birth (mm/dd/yy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Is the youth named above in Foster Care within the state of Georgia  Yes  No

Note: If the youth is in Foster Care but not in the care of Georgia, please provide the state name \_\_\_\_\_

**Section 1**

- A. Is the youth applicant a U.S. citizen or qualified alien?  Yes  No
- B. Is the youth applicant a Georgia resident?  Yes  No
- C. Does the youth applicant fall into one (1) or more of the three categories below (Answer YES or NO and check all categories below that apply to the youth)?:  Yes  No
  - \_\_\_\_ Youth applicant is between the age of 5 and 17 years old; **OR**
  - \_\_\_\_ Youth applicant is 18 years old and currently enrolled in school (*high school, GED program or equivalent, or post secondary institution*) and will be enrolled in AND attend school during the upcoming academic year (*Verification of school enrollment includes a letter from the school on official school letterhead*): **OR**
  - \_\_\_\_ Youth applicant is 18 - 19 years old and has a dependent child AND is the custodial parent

**If one (1) or more answers to the questions in Section 1 is NO, the youth IS NOT eligible to participate in the DFCS funded services. If the answer to ALL of the questions in Section 1 is YES, please complete the remainder of the form.**

**Section 2**

Does the youth currently receive benefits or services under any of the programs listed below (Please Note: you will have to provide official verification to the afterschool/summer program. See Appendix C for acceptable forms of verification):

		Yes	No
A.	Temporary Assistance for Needy Families (TANF)	<input type="checkbox"/>	<input type="checkbox"/>
B.	Supplemental Nutrition Assistance Program (SNAP) ( <i>also known as Food Stamps</i> )	<input type="checkbox"/>	<input type="checkbox"/>
C.	Medicaid or Social Security Income (SSI)	<input type="checkbox"/>	<input type="checkbox"/>
D.	Reduced or free lunch program at school – <i>Note: This eligibility is only for single youth eligibility. This is not applicable if the entire school population is awarded free lunch in universal eligibility.</i>	<input type="checkbox"/>	<input type="checkbox"/>
E.	Peachcare for Kids	<input type="checkbox"/>	<input type="checkbox"/>

**If the answer to at least one question in section 2 is YES, the youth is eligible to participate in the program and the parent/custodian/guardian may complete Section 5. Verification for receipt of services checked in Section 2 must be provided and a copy of the verification must be attached to this eligibility form. If the program does not receive verification of items checked in Section 2, the youth will not be able to participate in the program.**

**If the answer to ALL of the questions in Section 2 is NO, the parent/custodian/guardian MUST complete Section 3, Section 4 and Section 5 for eligibility determination. Verification for items listed in Section 3 and Section 4 must be provided and a copy of the verification must be attached to this eligibility form.**

**Section 3**

If you answered NO to ALL of the questions in Section 2, please review the chart below and enter your family unit size, gross household yearly income and gross household monthly income to determine eligibility.

*Family Income Eligibility for the DFCS Afterschool Care Program Income Eligibility Guide*

Number of Persons in Family Unit	Federal Poverty Level *	DFCS Afterschool Care Program Annual Household Income Guidelines **	DFCS Afterschool Care Program Monthly Household Income Guidelines
1	\$12,760.00	\$38,280.00	\$3,190
2	\$17,240.00	\$51,720.00	\$4,310
3	\$21,720.00	\$65,160.00	\$5,430
4	\$26,200.00	\$78,600.00	\$6,550
5	\$30,680.00	\$92,040.00	\$7,670
6	\$35,160.00	\$105,480.00	\$8,790
7	\$39,640.00	\$118,920.00	\$9,910
8	\$44,120.00	\$132,360.00	\$11,030
Each additional person, add	\$4,480	Multiply total Federal Poverty Level by 300%	Divide DFCS Afterschool Care Annual Household Income by 12.

\* Income based on the Office of the Secretary, U.S. Department of Health and Human Services (HHS) 2020 Poverty Guidelines for the 48 Contiguous States and the District of Columbia. (Source: 85 FR 360, Page 3060-3061, Document Number: 2020-00858)

\*\* 300 % of the federal poverty level in effect January 15, 2020.

Family Unit Size\* \_\_\_\_\_  
 Gross Household Yearly Income \$ \_\_\_\_\_ Gross Household Monthly Income \$ \_\_\_\_\_

\* See Appendix A for definition of family unit.

**Section 4**

Please complete Section 4 by listing your name, the name of the child (ren) who live with you, and the other parent of the child (ren) if s/he lives with you. List any gross monthly income for each.

Household Composition and Income					
<i>Gross Monthly Income is income before taxes and deductions.</i>					
Name (First, Middle, and Last)	Relationship	Date of Birth (MM/DD/YY)	Income Source	Amount (Gross Monthly Income)	How often received?
	SELF				



**Section 5**

Please review and sign Section 5 as notification and signature of verification.

**Applicant Notification and Signature**

We are asking for your youth's Social Security number because any person applying for or receiving federal benefits must give us his or her Social Security number. Federal law 409(a) (4) of the Social Security Act and federal regulations (45 CFR 264.10) allow us to collect this information.

By signing this application,

- I swear, under penalty of perjury, that to the best of my knowledge, all the information and statements I've provided in this application are true, and
- I promise to cooperate with any effort to verify the information provided.
- If selected to participate in the program, I promise to abide by all rules and guidelines.

**Parent/Guardian/Caregiver Information – This section must be completed in its entirety.**

Name of Parent/Guardian/Caregiver (Last, First, MI) \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell# \_\_\_\_\_

\_\_\_\_\_  
 Parent/Caregiver/Guardian Printed Name \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
 Parent/Caregiver/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Official Use Only Section for DFCS Funded Afterschool/Summer Service Provider:**

**Total Income:** \$ \_\_\_\_\_ **Per:** Week  Every 2 Weeks  Twice monthly  Monthly **Household Size:** \_\_\_\_\_  
**Annual Income Conversion:** Weekly x 4.3333, Every 2 Weeks x 2.1666, Twice Monthly x 2, Monthly x 1  
**Total Converted Annual Income:** \$ \_\_\_\_\_ (Round to the nearest whole number)

By signing below, I certify the information presented within this form was reviewed, verified and confirmed\*\* and meets the DFCS Afterschool Care Program Eligibility rules and guidelines indicated within this form. I also certify this form will be kept in the youth participant's file in a confidential and secured location.

\_\_\_\_\_  
 Authorized Program Staff Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

\*\* See Appendix B for income verification proof sources

## APPENDICES

### **\*Appendix A: Family Unit**

The Department of Human Services Temporary Assistance for Needy Families (TANF) definition of family includes the dependent child for whom assistance is requested and certain other individuals living in the home with the child who are required to be included in the family.

The following individuals are considered members of the Family Unit:

- A biological or adoptive parent of the dependent child for whom assistance is requested;
- An eligible minor sibling, (whole, half or adoptive) of the dependent child for whom assistance is requested;
- Other children living in the home who are within the specified degree of relationship to the grantee relative but who are not members of the Family Unit; and
- A non-parent relative who is the caretaker if there is no parent in the home or if the only parent in the home receives SSI.

### **\*\*Appendix B: Income Proof Sources and Applicable Income Sources**

Income verification must be obtained and a copy must be attached to the youth's income eligibility form.

#### **Examples of earned income verification are:**

- Pay stubs or receipts for the most recent four weeks of earnings;
- W-2 Forms;
- Employer's issued, signed and dated documentation;
- Personal income ledger or tablet (e.g. self-employed)
- Quarterly income tax returns;
- Annual income tax returns when presented in January – March quarter;
- Letter/statement from employer;
- Documentation from other DFCS staff such as the eligibility CM; and/or
- Form 809 or itemized statement completed by the employer.

#### **Examples of unearned income verification are:**

- Copy of current check with check stubs (within last 4 weeks);
- Award letters or written, signed and dated statement of payer;
- Social Security Records;
- Worker's compensation records;
- Form 139 – Contribution statement;
- Unemployment insurance claim records;
- Georgia Gateway screen information; and/or
- STARS.

*See page 2 of Appendix B for applicable income sources.*

Applicable Income

Each of the following sources of income is budgeted in determining eligibility:

Earned

- Wages or salary – Gross income of the applicant is used to determine eligibility
- Net Income from Self-Employment
- Employee commission
- Jury Duty
- Rental Income – (regular and ongoing payments – if engaged in management of property for an average of 20 hours or more per week)
- Roomer Income – (regular and ongoing payments)

Unearned

- Military Allotments
- Cash gifts Charitable gift exceeding \$300 received from and organization receiving state or federal funds
- Inheritances
- Insurance Benefits due to Loss of Income – benefits paid from an insurance policy due to loss of income
- Social Security Benefits
- Unemployment Compensation
- Worker’s Compensation
- Alimony – (regular and ongoing payments)
- Child Support – (regular and ongoing payments)
- Farm Allotment – payments received from government-sponsored programs, such as Agricultural Stabilization and Conservation Services
- Veteran’s Benefits
- Capital Gains
- Interest/Annuity
- Capital Gains/Dividends
- Pension
- Trust Fund
- Disability Payment
- Boarder Income – (regular and ongoing payments)
- Rental Income – (regular and ongoing payments - if engaged in management of property for an average of 20 hours or less per week)
- Deferred compensation through retirement plan

**\*\*Appendix C: Acceptable Verification of Benefits or Services**

- **Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Medicaid, and PeachCare:** Official documentation showing the family/youth is currently receiving benefits at the time of application/enrollment into the afterschool care program (Integrated Eligibility System (IES) documentation, Official Letter from the Georgia Division of Family and Children Services outlining the receipt of benefits).
- **Supplemental Security Income (SSI):** Award letter from the Social Security Administration
- **Free or Reduced Lunch:** Award letter identifying free or reduced lunch as established by individual family eligibility. Note: Programs may receive a listing of students receiving free or reduced lunch granted the listing is on official school letterhead with the disclaimer that all free or reduced lunch eligibility is determined by individual family application. Universal, school-wide, city-wide or district-wide free lunch does not qualify as an acceptable point of eligibility for the DFCS Afterschool Care Program.

**The following physical  
evaluation can be used at the  
Med Group if you see an on-base  
provider.**

# 23D MDG, MOODY AFB SPORTS PHYSICAL

HEALTH RECORD	<b>CHRONOLOGICAL RECORD OF MEDICAL CARE</b>	
DATE	<u>SECTION 1: PARENT OR PARTICIPANT TO COMPLETE</u>	
	1. Have you had a medical illness or injury since your last checkup or sports physical?	YES/NO
	2. Have you ever been hospitalized overnight?	YES/NO
	3. Have you ever had surgery?	YES/NO
	4. Are you currently taking any prescription or nonprescription (over the counter) medications?	YES/NO
	5. Have you ever used an inhaler?	YES/NO
	6. Have you ever passed out during exercise?	YES/NO
	7. Have you ever had chest pain during or after exercise?	YES/NO
	8. Do you get tired more quickly than your friends do during exercise?	YES/NO
	9. Have you ever had racing of your heart or skipped heartbeats?	YES/NO
	10. Have you ever had high blood pressure or high cholesterol?	YES/NO
	11. Have you ever been told you have a heart murmur?	YES/NO
	12. Has anyone in the family died of heart problems or sudden death before age 50?	YES/NO
	13. Has a physician ever denied or restricted your participation in sports for heart problems?	YES/NO
	14. Do you have any current skin problems (itching, rashes, acne, warts, fungus, or blisters)?	YES/NO
	15. Have you ever had a head injury or concussion?	YES/NO
	16. Have you ever had a seizure?	YES/NO
	17. Have you ever become ill from exercising in the heat?	YES/NO
	18. Do you cough, wheeze, or have trouble breathing during or after activity?	YES/NO
	19. Do you have asthma?	YES/NO
	20. Have you ever had problems with your eyes or vision?	YES/NO
	21. Have you broken or fractured any bones or dislocated any joints?	YES/NO
	22. Have you ever had any other problems with pain or swelling in muscles, tendons, bones, or joints?	YES/NO
	23. Have you had a medical illness or injury since your last checkup or sports physical?	YES/NO

ALLERGIES TO MEDICINES:  
OTHER ALLERGIES:

EXPLANATION OF "YES" ANSWERS:

RECORDS MAINTAINED AT:			
PATIENT'S NAME ( Last, First, Middle initial )		SEX	
RELATIONSHIP TO SPONSOR:	STATUS		RANK/GRADE
SPONSOR'S NAME		ORGANIZATION	
DEPART/SERVICE	SSN/IDENTIFICATION NO.		DATE OF BIRTH

# 23 D MDG, MOODY AFB SPORTS PHYSICAL

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION <i>(Sign each entry)</i>					
<b>CONTACT INFORMATION:</b>						
<b>In case of emergency, notify:</b>						
	<i>I. Name</i>	<i>Phone: Home</i>	<i>Work</i>	<i>Cell</i>		
	<i>I. Name</i>	<i>Phone: Home</i>	<i>Work</i>	<i>Cell</i>		
	<b>Physician:</b>	<b>Physician's Phone</b>				
<b><i>I hereby state that to the best of my knowledge, the above answers are complete</i></b>						
	Parent/ Athlete:			Date:		
<b><u>SECTION 2: TECHNICIAN AND PROVIDER COMPLETE</u></b>						
	<b>Vitals:</b>	<b>BP:</b>	<b>Pulse:</b>	<b>Resp:</b>	<b>Weight:</b>	<b>Height:</b> (____%ile)
	Medical:	Appearance:			Normal	Abnormal
		Eyes, Ears, Nose, Throat			Normal	Abnormal
		Lymph Nodes			Normal	Abnormal
		Cardiovascular			Normal	Abnormal
		Lungs			Normal	Abnormal
		Genitalia (boys)			Normal	Abnormal
		Skin			Normal	Abnormal
	Musculoskeletal:	Neck			Normal	Abnormal
		Spine			Normal	Abnormal
		Upper Extremities			Normal	Abnormal
		Lower extremities			Normal	Abnormal
	<input type="checkbox"/> Cleared to participate in all athletics					
	<input type="checkbox"/> Cleared to participate in all athletics with the following exceptions:					
	<input type="checkbox"/> Needs further evaluation:					
	PROVIDER SIGNATURE AND STAMP					DATE

**The following physical evaluation can be used at an off-base provider or walk-in clinic if you are NOT seen at the Med Group.**

**PREPARTICIPATION PHYSICAL EVALUATION  
HISTORY FORM**

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

\_\_\_\_\_

\_\_\_\_\_

Do you have any allergies?  Yes  No If yes, please identify specific allergy below.

Medicines  Pollens  Food  Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_



# ■ PREPARTICIPATION PHYSICAL EVALUATION

## THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	<b>Yes</b>	<b>No</b>
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

**Explain "yes" answers here**

---



---



---



---



---

**Please indicate if you have ever had any of the following.**

	<b>Yes</b>	<b>No</b>
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

**Explain "yes" answers here**

---



---



---



---



---

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

# PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

## PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
  - Do you feel stressed out or under a lot of pressure?
  - Do you ever feel sad, hopeless, depressed, or anxious?
  - Do you feel safe at your home or residence?
  - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
  - During the past 30 days, did you use chewing tobacco, snuff, or dip?
  - Do you drink alcohol or use any other drugs?
  - Have you ever taken anabolic steroids or used any other performance supplement?
  - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
  - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female	
BP	/ ( / )	Pulse	Vision R 20/ L 20/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat • Pupils equal • Hearing			
Lymph nodes			
Heart <sup>a</sup> • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only) <sup>b</sup>			
Skin • HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic <sup>c</sup>			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional • Duck-walk, single leg hop			

<sup>a</sup>Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

<sup>b</sup>Consider GU exam if in private setting. Having third party present is recommended.

<sup>c</sup>Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_

- Not cleared
- Pending further evaluation
- For any sports
- For certain sports \_\_\_\_\_
- Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

**I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).**

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

# ■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name \_\_\_\_\_ Sex  M  F Age \_\_\_\_\_ Date of birth \_\_\_\_\_

Cleared for all sports without restriction

Cleared for all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_

Not cleared

Pending further evaluation

For any sports

For certain sports \_\_\_\_\_

Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).**

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

## EMERGENCY INFORMATION

Allergies \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other information \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_