

## **AF FORM 1181**

The Child-Care Permanent Record is maintained at the center and should be updated quarterly by parents. The name of an emergency contact person with home phone and duty phone (if applicable) should be listed on AF Form 1181. The emergency contact should be informed that they have been designated. Either parent's signature authorizes medical treatment, defined as measure necessary to protect your child in a life-threatening situation. Health concerns or other information considered critical should be annotated on AF Form 1181.

- The AF Form 1181 is maintained at the center for ready reference in the event of an accident, emergency or illness. The importance of accurately completing and regularly updating AF Form 1181 cannot be over emphasized. According to guidelines outlined under IAW AFI 34-248 for Child Development Programs, the Child Development Center is prohibited from admitting any child without a completed AF Form 1181. Any information provided by you on AF Form 1181 is protected by the Privacy Act. A copy of AF Form 357, Family Care Plan, if required, must also be completed and updated annually for your child(ren).
- All children must be signed in and out on the AF Form 1182 at the front desk and on AF Form 1930 in the child's classroom by parents or their appointees each time they attend the center. To ensure every child's safety, only parents or their designee may remove a child from the center. Children will not be released to siblings or other children under the age of 14. Identification will be required of all persons when picking up children, unless that person is known and recognized by the front desk and care giving staff.
- Children may not be left at the center for more than ten consecutive hours without a letter from the sponsor's commander. In the event children are left at the center after operating hours, every attempt will be made to contact the parents or the emergency contact by phone. If attempts are unsuccessful, the sponsor's unit will be contacted. As a last resort, security forces will be contacted for assistance in locating the parents or for temporary placement for the child(ren).
- Patrons can be denied child development program services. Examples of reasonable grounds for denial include (but are not limited to) failure to follow child development program rules and policies, inappropriate guidance techniques while at the center, rudeness to child development personnel, inappropriate language, continued tardiness on payments and continued tardiness when picking up children. The Support Group Commander must approve termination of services.

## AIR FORCE YOUTH FLIGHT PROGRAM PATRON REGISTRATION

### PRIVACY ACT STATEMENT

**AUTHORITY:** 10 USC 8013; 44 USC 3101; EO 9397

**PRINCIPAL PURPOSES:** To provide Youth Flight Programs with authorization for medical treatment in emergency situations; authorization for field trips; identify children and sponsor, record required immunizations; record known allergies; record income data; record special needs requirements; and record special instructions.

**ROUTINE USES:** Form may be furnished to civilian doctors or hospitals in course of obtaining emergency medical attention for children. Information furnished may be disclosed, upon request, to other Federal, state or local governmental agencies in the pursuit of their official duties. Finally, it may be used for other lawful purposes including law enforcement and litigation.

**DISCLOSURE IS VOLUNTARY:** Failure to furnish information, including SSN, will result in denial of admission of child(ren) to Youth Flight Programs. SSN is used for positive identification of individuals and records.

|                                                                                               |         |                                        |         |                                                   |        |                                        |        |             |           |                    |                                                                                                                                                               |        |                                  |
|-----------------------------------------------------------------------------------------------|---------|----------------------------------------|---------|---------------------------------------------------|--------|----------------------------------------|--------|-------------|-----------|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|----------------------------------|
| CHILD'S NAME                                                                                  |         | SPONSOR (Last, First, Middle Initial)  |         |                                                   |        | SPOUSE (Last, First, Middle Initial)   |        |             |           | FEES               |                                                                                                                                                               |        |                                  |
| HOME PHONE/ <a href="#">CELL PHONE</a>                                                        |         | RANK/GRADE                             |         |                                                   |        | RANK/GRADE                             |        |             |           | DEROS/ID EXPIRES   |                                                                                                                                                               |        |                                  |
| ADDRESS                                                                                       |         | DUTY PHONE/ <a href="#">CELL PHONE</a> |         |                                                   |        | DUTY PHONE/ <a href="#">CELL PHONE</a> |        |             |           | BRANCH OF SERVICES |                                                                                                                                                               |        |                                  |
|                                                                                               |         | ORGANIZATION                           |         |                                                   |        | EMERGENCY CONTACT <a href="#">NAME</a> |        |             |           | EMERGENCY PHONE    |                                                                                                                                                               |        |                                  |
| MARITAL STATUS                                                                                |         | SPONSOR'S SSN                          |         |                                                   |        | SPOUSE'S SSN                           |        |             |           | HOSPITAL PHONE     |                                                                                                                                                               |        |                                  |
|                                                                                               |         |                                        |         |                                                   |        |                                        |        |             |           | PHYSICIAN'S NAME   |                                                                                                                                                               |        |                                  |
| VACCINE / DATE RECEIVED                                                                       | BIRTH   | 2 MOS                                  | 4 MOS   | 6 MOS                                             | 12 MOS | 15 MOS                                 | 18 MOS | 4-6 MOS     | 11-12 MOS | 14-16 MOS          | SEX (X One)                                                                                                                                                   | MALE   | DATE OF BIRTH (Day, Month, Year) |
|                                                                                               |         |                                        |         |                                                   |        |                                        |        |             |           |                    |                                                                                                                                                               | FEMALE |                                  |
| Hepatitis B 1st                                                                               | Hep B-1 |                                        |         |                                                   |        |                                        |        |             |           |                    | I authorize emergency treatment for the children named hereon:                                                                                                |        |                                  |
| 2nd                                                                                           |         |                                        |         |                                                   |        |                                        |        |             |           |                    |                                                                                                                                                               |        |                                  |
| 3rd                                                                                           | Hep B-2 |                                        | Hep B-2 |                                                   |        |                                        |        |             | Hep B     |                    |                                                                                                                                                               |        |                                  |
| 4th                                                                                           |         |                                        |         |                                                   |        |                                        |        |             |           |                    |                                                                                                                                                               |        |                                  |
| Diphtheria-Tetanus, Pertussis 1st                                                             |         |                                        |         |                                                   |        |                                        |        |             |           |                    | SIGNATURE                                                                                                                                                     |        | DATE (YYYYMMDD)                  |
| 2nd                                                                                           |         |                                        |         |                                                   |        |                                        |        |             |           |                    | SPECIAL INSTRUCTIONS                                                                                                                                          |        |                                  |
| 3rd                                                                                           | DTP     | DTP                                    | DTP     | DTP                                               |        |                                        |        | DTP OR DTAP | Td        |                    |                                                                                                                                                               |        |                                  |
| 4th                                                                                           |         |                                        |         |                                                   |        |                                        |        |             |           |                    |                                                                                                                                                               |        |                                  |
| 5th                                                                                           |         |                                        |         |                                                   |        |                                        |        |             |           |                    |                                                                                                                                                               |        |                                  |
| 6th                                                                                           |         |                                        |         |                                                   |        |                                        |        |             |           |                    |                                                                                                                                                               |        |                                  |
| H. Influenzane type b 1st                                                                     |         |                                        |         |                                                   |        |                                        |        |             |           |                    | SPECIAL NEEDS CARE /CHRONIC ILLNESSES /ALLERGIES                                                                                                              |        |                                  |
| 2nd                                                                                           |         |                                        |         |                                                   |        |                                        |        |             |           |                    |                                                                                                                                                               |        |                                  |
| 3rd                                                                                           | Hib     | Hib                                    | Hib     | Hib                                               |        |                                        |        |             |           |                    |                                                                                                                                                               |        |                                  |
| 4th                                                                                           |         |                                        |         |                                                   |        |                                        |        |             |           |                    |                                                                                                                                                               |        |                                  |
| Polio 1st                                                                                     |         |                                        |         |                                                   |        |                                        |        |             |           |                    | ADULTS AUTHORIZED TO SIGN CHILDREN IN / OUT                                                                                                                   |        |                                  |
| 2nd                                                                                           |         |                                        |         |                                                   |        |                                        |        |             |           |                    |                                                                                                                                                               |        |                                  |
| 3rd                                                                                           | OPV     | OPV                                    | OPV     |                                                   |        |                                        |        | OPV         |           |                    |                                                                                                                                                               |        |                                  |
| 4th                                                                                           |         |                                        |         |                                                   |        |                                        |        |             |           |                    |                                                                                                                                                               |        |                                  |
| Measles, Mumps, Rubella 1st                                                                   |         |                                        |         |                                                   |        |                                        |        |             |           |                    | AUTHORIZED FOR FIELD TRIPS                                                                                                                                    |        |                                  |
| 2nd                                                                                           |         |                                        |         |                                                   |        |                                        |        |             |           |                    |                                                                                                                                                               |        |                                  |
| Varicella Zoster Virus Vaccine 1st                                                            |         |                                        |         |                                                   |        |                                        |        |             |           |                    |                                                                                                                                                               |        |                                  |
| 2nd                                                                                           |         |                                        |         |                                                   |        |                                        |        |             |           |                    |                                                                                                                                                               |        |                                  |
| OTHER IMMUNIZATIONS AS REQUIRED:                                                              |         |                                        |         | NAMES OF ADDITIONAL CHILDREN ENROLLED IN PROGRAM: |        |                                        |        |             |           |                    |                                                                                                                                                               |        |                                  |
| VACCINE TYPE:                                                                                 |         | DATE:                                  |         |                                                   |        |                                        |        |             |           |                    |                                                                                                                                                               |        |                                  |
| VACCINE TYPE:                                                                                 |         | DATE:                                  |         |                                                   |        |                                        |        |             |           |                    |                                                                                                                                                               |        |                                  |
| VACCINE TYPE:                                                                                 |         | DATE:                                  |         |                                                   |        |                                        |        |             |           |                    |                                                                                                                                                               |        |                                  |
| VACCINE TYPE:                                                                                 |         | DATE:                                  |         |                                                   |        |                                        |        |             |           |                    |                                                                                                                                                               |        |                                  |
| FAMILY INCOME (Adjusted gross—most recent 1040) : PROVIDE ONLY IF REDUCED FEES ARE REQUESTED. |         |                                        |         |                                                   |        |                                        |        |             |           |                    | IT IS THE RESPONSIBILITY OF EACH SPONSOR TO ENSURE IMMUNIZATIONS AND EMERGENCY INFORMATION IS UP TO DATE. FAILURE TO UPDATE MAY RESULT IN REFUSAL OF SERVICE. |        |                                  |
| \$ <b>SINGLE / DUAL INCOME (Circle One)</b> \$                                                |         |                                        |         |                                                   |        |                                        |        |             |           |                    |                                                                                                                                                               |        |                                  |
| PARENT SIGNATURE                                                                              |         |                                        |         |                                                   |        |                                        |        |             |           |                    |                                                                                                                                                               |        |                                  |