

Commonwealth Challenge Application (Part One)

Virginia Commonwealth Challenge Youth Academy
Attn: Admissions
Bldg. 253 C Street
Camp Pendleton
Virginia Beach, VA 23451

To apply for admission complete the following Application as thoroughly as possible and attach required forms. PLEASE DO NOT LEAVE ANY FORM BLANK. **Scan and email application (to admissions@vachallenge.org), mail application or fax to (757) 491-2146. After we receive the complete Part One, we will email you Part Two.**

Provide the following documents in this order:

- ❖ Application Forms: Complete pages 1 and 2 entirely and accurately.
- ❖ Legal Information Form.
- ❖ Court Documents that: Provide charge(s), type(s) of charge(s), pending court dates, results of charge(s).
- ❖ Consent for Release of School Information Form.
- ❖ School Transcript(s): Obtain a copy from the school.
- ❖ Medical History Survey: **Parents and the child will fill this form out and sign it.**
- ❖ Mental Health Survey **Parents and the child will fill this form out and sign it.**
- ❖ Mentor Application: Bring your mentor or potential mentor with you to Orientation. Questions about Mentors can be answered by calling (757) 491-5932 Ext 240 .

Important Supporting Documents needed for Part One

- ❖ Birth Certificate: Provide a copy of your birth certificate or legal permanent resident card
- ❖ Individual Education Plan/504 (IEP)
- ❖ Social Security Card: Provide a copy of your social security card.
- ❖ Child Custody Documents/Adoption Papers: Please provide us the most current copy of any child custody documents/adoption papers.

Once you submit all the above paperwork, we will email you Part Two.

PART TWO OF THE APPLICATION WILL REQUIRE:

- ❖ Medical Insurance Verification: Provide a copy of your insurance card front & back.
- ❖ A valid Virginia ID card: provide for GED testing (Note: Needed after 2nd pass).
- ❖ Provide a copy of your most current immunization record.
- ❖ TB skin test or chest x-ray: must be done within 12 months prior to the start of class.
- ❖ Physical Exam (Form will be sent to you with Part Two of the application. Use OUR form ONLY. No School/Doctor Office Physical Forms.)
- ❖ Medical Authorization/Prescription Form (will be sent to you with Part Two)

Commonwealth Challenge Youth Academy

Legal Form

Last Name

First Name

MI

Candidate's Name:

Please Note: We can't accept any applicant who has been convicted of a felony, or who is currently on a "deferred entry of judgment". The felony MUST be reduced to a misdemeanor or expunged before acceptance. You must have your probation officer sign this form. Any false or misleading information could result in denial or termination from the Challenge Academy. Please click the boxes (Yes/No) with your answers.

1. Have you ever been arrested, apprehended, charged, cited, or held by federal, state or other law enforcement or juvenile authorities, regardless of whether the citation was dropped, dismissed or found not guilty in any state? YES NO

** If your answer is "NO", sign and go to the next page. **

2. If your answer to question #1 was "YES", please answer the following: What were you charged with; the dates; the locations; outcomes; PLEASE BE THOROUGH!

| Date | Nature of Offense or Violation | Law Enforcement Agency | Outcome |
|----------------------|--------------------------------|------------------------|-------------------|
| a. _____/_____/_____ | _____/_____/_____ | _____/_____/_____ | _____/_____/_____ |
| b. _____/_____/_____ | _____/_____/_____ | _____/_____/_____ | _____/_____/_____ |
| c. _____/_____/_____ | _____/_____/_____ | _____/_____/_____ | _____/_____/_____ |
| d. _____/_____/_____ | _____/_____/_____ | _____/_____/_____ | _____/_____/_____ |

YOU MUST ATTACH ALL DOCUMENTS RELATING TO THE INCIDENT'S LISTED ABOVE (disposition summary of charges, minute orders, tickets, outcomes showing the status of charge (misdemeanor/felony))

3. Are you currently awaiting a hearing or sentencing? YES NO
a. If you are awaiting a hearing or sentencing, what is the scheduled date? _____

60 Where will the hearing or sentencing take place? (city, county) _____

70 Are any of the above charges a felony? YES NO
c0 If "YES", which one(s): _____

80 Are you currently on probation? YES NO for how long? _____

c0 Who is your probation officer: _____

d0 What is your probation officer's phone number: _____

90 Are you currently doing community service? YES NO
a. If yes, how many hours do you have pending? _____

Signature of Parent/Guardian _____ Date _____

Signature of Applicant: _____ Date _____

Signature of Probation Officer: _____ Date: _____

Print Name of Probation Officer: _____ Email: _____

AUTHORITY: Public Law 102-484, Sec. 1091 e (2)

Principle Purpose: To select applicants for participation in the Virginia Commonwealth Youth ChalleNge Academy. Medical information is solicited so that successful applicants may be provided safe and effective medical treatment in the event of illness or injury.

Disclosure: Disclosure is voluntary, however, applicants who do not provide requested information will not be considered for participation in the Commonwealth Challenge youth Academy.

The Virginia Commonwealth ChalleNge Youth Academy is a non-profit organization sponsored by the Virginia National Guard. Our purpose is to provide a highly disciplined atmosphere which foster academics, leadership development, and personal growth. The Virginia Commonwealth ChalleNge Youth Academy serves unemployed or underemployed 16-18 year old youth. who have withdrawn or have dropped out of high school, without regard to race, color, national origin, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity.

Youth participants shall be informed of the following: Participants receiving training under the Program established by this guidance are neither Federal employees nor members of the National Guard. The participants shall be considered Federal employees under Sub chapter I of Chapter 81 of Title 5, U.S. Code, for the purpose of compensation for work injuries; and for the purpose of Sections 1346(b) and Chapter 171 of Title 28, U.S. Code, and any other provision of law relating to the liability of the United States for tortuous conduct of employees of the United States. The participants shall not be considered to be in the performance of duty while not at the assigned location of training or other activity authorized in accordance with the Program Agreement except. When the participant is traveling to or from the location or is on pass from that training or other activity. In computing compensation benefits for disability or death, the monthly pay of a participant shall be deemed that received under the entrance salary for a grade GS-2 Federal employee. The entitlement of a person to receive compensation for a disability shall begin on the day following the date that the person's participation in the Program is terminated.

Basic Eligibility Criteria

- ❖ **Must be between 16-18 years of age at time of entry into the Challenge Academy.**
- ❖ **Must have a Mentor identified who must live in the same state as the Mentee**
- ❖ **Physically and mentally capable of participating in the program with reasonable accommodations.**
- ❖ **Withdrawn/Transferred or have dropped out of high school.**
- ❖ **Unemployed or underemployed.**
- ❖ **No felony convictions or pending felony Charges.**
- ❖ **You can be on parole or probation for misdemeanor charges only.**
- ❖ **Citizen or legal resident of the United States.**
- ❖ **Must be a resident of Virginia**

Parent/Guardian Signature: _____

Date: _____

Candidate Signature: _____

Date: _____

Application Form

Section A: Applicant Information

| | | | | | | | | |
|-----------|----------------------|----------------|----------------------|------------|----------------------|----------|----------------------|----------------------|
| Last Name | <input type="text"/> | Middle Name | <input type="text"/> | First Name | <input type="text"/> | | | |
| SSN | <input type="text"/> | D.O.B MM/DD/YY | <input type="text"/> | AGE | <input type="text"/> | SEX | M / F | <input type="text"/> |
| Address | <input type="text"/> | City | <input type="text"/> | State | <input type="text"/> | Zip Code | <input type="text"/> | |

Ethnicity/Race Please click the box with your answer

| | | | | | |
|--|---|--------------------------------|---|------------------------------------|--|
| <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> American Indian | <input type="checkbox"/> Asian | <input type="checkbox"/> African American | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Alaska Native | <input type="checkbox"/> Pacific Islander | <input type="checkbox"/> Other | <input type="text"/> | | |

| | | | | | | | |
|-----------------|----------------------|--------|----------------------|------------|----------------------|-----------|----------------------|
| Height (inches) | <input type="text"/> | Weight | <input type="text"/> | Hair Color | <input type="text"/> | Eye Color | <input type="text"/> |
| Shirt: | <input type="text"/> | Pants: | <input type="text"/> | Shoe Size | <input type="text"/> | | |

Family Life Do you the applicant have any child(ren)? Yes No

Do you (the applicant) have legal Custody of your child(ren) Yes No

If No who has legal custody

How old are your children

Who will be caring for your child(ren) while you are attending CCYA?

Parent/Guardian Please provide the court documents showing the names(s) of the individual(s) awarded legal custody of the applicant to include adoption papers (If applicable) in addition to any No contact orders or visitation rights.

Name Parent/Guardian Cell

Address City St. Zip Code

Parent Email

Emergency Contact

Relationship Name Cell phone number

Relationship Name Cell phone number

Affirmation of information.

By submitting this application, I affirm that all information and statements that I have provided are accurate and true to the best of my knowledge, and fully understand that any false statements will disqualify my child from the academy.

I agree to the Challenge Academy administering a drug and alcohol test to my child son/daughter will be tested by qualified individuals for drugs and alcohol as part of his/her physical examination. I further understand that during the course of the program, my child will be randomly tested for drugs and alcohol. Any positive results may result in disenrollment.

I approve of the Challenge Academy using my child's photo or likeness of, and voice for any video, DVD, radio, TV programs or interviews and Internet presentations to include Facebook, YouTube and any other social media outlets to promote the Commonwealth Challenge Youth Academy. A photographer chosen by the Challenge Academy can take pictures of my son/daughter for the purpose of Awards Banquet, Family Day and the Yearbook or Yearbook DVD.

Monitoring of Cadets by Surveillance Cameras; 24/7

Cadets are monitored by camera twenty four hours a day, seven days a week in the barracks, HQ, academic buildings, the dining hall and all common areas. Cadets are to be in either school or physical training (PT) uniforms at all times in their barracks, hallways, coming in and out of the shower or latrine, and the academy area. Cadets will be in proper uniform according to CCYA policy and cadet handbook. Uniform changes may be dictated by the Team Leader depending on the situation. If my son/daughter tampers or destroys any of the surveillance cameras he/she may be terminated and the parents or guardians will be held liable for the damage and billed by the state.

Parent Signature

Candidate Signature

How did you hear about CCYA?

(Please select one)



Commonwealth Challenge Youth Academy
253 C St. Camp Pendleton
Virginia Beach, VA 23451

Consent for Release of Information/Academic Program Request

Student (S) Information

Name _____ DOB _____

School Name _____

Address _____ City _____ ST _____ Zip code _____

What grade are you currently in? 9th 10th 11th 12th

The following information requested will be use to assist the staff of the Virginia Commonwealth Challenge Youth Academy in evaluating and assessing the student's application and designing an individual education program for each student. ***Does the student have a current IEP/504 or Learning Disability? Please provide a copy*.**

Have you ever been suspended or expelled from school? Why? _____

- | | |
|---|---|
| <input type="checkbox"/> Grade transcripts | <input type="checkbox"/> Individual Education Plans (IEP) / 504Plan (if applicable) |
| <input type="checkbox"/> Standardized test records | <input type="checkbox"/> Tri-annual reviews |
| <input type="checkbox"/> Special Education evaluation (if applicable) | <input type="checkbox"/> Social history |
| <input type="checkbox"/> Withdrawal/Transfer form | <input type="checkbox"/> Immunization and health records |

****Commonwealth Challenge Youth Academy Program Enrollment****

Please select which program you would like for your child/student: ☐ GED ☐ Credit Accrual/Recovery

****Guidance Counselor or School Official must complete this portion****

Credit Accrual/Recovery Program Virtual Learning program is to provide an opportunity for Virginia students to take a virtual or online course through an accredited online learning platform. In order to recover a course previously taken or continue on graduation path. We currently use the Edgenuity learning platform.

Credit Accrual/Recovery Program Select ONLY: one course per subject. If a student failed the course and needs to retake the course or Take a course, indicate the selection by checking the box before subject name. If only 1st or 2nd semester course is needed, please circle A (1st semester) or B (2nd semester).

- | | |
|---|---|
| <input type="checkbox"/> English 9 (A or B) | <input type="checkbox"/> Algebra I (A or B) |
| <input type="checkbox"/> English 10 (A or B) | <input type="checkbox"/> Algebra II (A or B) |
| <input type="checkbox"/> English 11 (A or B) | <input type="checkbox"/> Algebra Functions & Data Analysis (A or B) |
| <input type="checkbox"/> English 12 (A or B) | <input type="checkbox"/> Geometry (A or B) |
| <input type="checkbox"/> Earth Science (A or B) | <input type="checkbox"/> World History & Geography I (A or B) |
| <input type="checkbox"/> Biology I (A or B) | <input type="checkbox"/> World History & Geography II (A or B) |
| <input type="checkbox"/> Biology II-Ecology | <input type="checkbox"/> VA/US History (A or B) |
| <input type="checkbox"/> Chemistry (A or B) | <input type="checkbox"/> VA/US Government (A or B) |
| <input type="checkbox"/> Economics & Personal Finance(A or B) | |

Parent/Guardian signature _____ Student Signature _____

School Counselor Name _____ Counselor's Phone Number _____

Signature _____ Date _____

Medical Survey

PURPOSE: This survey must be completed by a parent/guardian in order for the youth to participate in the **22 week residential program which utilizes a highly structured quasi-military format.** **Understandably youth will need to be able to with stand the physical and emotional stressors during their transition into the CCYA lifestyle.** These questions are designed to determine if the youth has developed any condition, which would make it hazardous to participate in CCYA academic/athletic program. "Yes" answers are not necessarily disqualifiers. Dishonesty or non-disclosure of medical history are disqualifiers. **PLEASE CLICK THE BOXES WITH YOUR ANSWERS**

Candidates Name: _____ Sex _____ Age _____ Date of Birth _____

In case of emergency Contact:

Name _____ Relationship _____ Phone (C) _____ (W) _____

Name _____ Relationship _____ Phone (C) _____ (W) _____

| HAVE YOU EVER HAD OR DO YOU NOW HAVE: | YES | NO | HAVE YOU EVER HAD OR DO YOU NOW HAVE: | YES | NO |
|---|-----|----|---|-----|----|
| (1) Asthma, wheezing, or inhaler use | | | (34) Limitation of motion of any joint, including knee, shoulder, wrist, elbow, hip or other joint | | |
| (2) Dislocated joint, including knee, hip, shoulder, elbow, ankle or other joint | | | (35) Drug or alcohol rehab | | |
| (3) Epilepsy, fits, seizures, or convulsions | | | (36) Kidney, urinary tract or bladder problems, surgery, stones or other urinary tract problems | | |
| (4) Sleepwalking | | | (37) Sugar, protein or blood in urine | | |
| (5) Recurrent neck or back pain | | | (38) Surgery on a bone or joint (knee, shoulder, elbow, wrist, etc.) including Arthroscopy with normal findings | | |
| (6) Rheumatic fever | | | (39) Pain or swelling at the site of an old fracture | | |
| (7) Foot pain | | | (40) Shoulder, knee, or elbow problem (out of place) | | |
| (8) A swollen, painful, or dislocated joint or fluid in a joint (knee, shoulder, wrist, elbow, etc.) | | | (41) Perforated ear drum or tubes in ear drum(s) | | |
| (9) Double vision | | | (42) Locking of the knee or other joint | | |
| (10) Periods of unconsciousness | | | (43) Anemia | | |
| (11) Frequent or severe headaches causing loss of time from work or school or taking medication to prevent frequent or severe headaches | | | (44) Giving way of knee or other joint | | |
| (12) Wear contact lenses | | | (45) Ear surgery, to include mastoidectomy or repair of perforated ear drum, hearing loss or need/use a hearing aid | | |
| (13) Fainting spells or passing out | | | (46) Cataracts or surgery for cataracts | | |

Medical Survey

Please click the box with your answer. Left Box is "Yes," Right Box is "No."

| | | | | | |
|---|--|--|---|--|--|
| (14) Head injury, including skull fracture, resulting in concussion, loss of consciousness, headaches, etc. | | | (47) Eye surgery, including radial keratotomy, lens implant or other eye surgery to improve your vision | | |
| (15) Back surgery | | | (48) Night blindness | | |
| (16) Any of the following skin diseases: | | | (49) Collapsed lung or other lung condition | | |
| (a) Eczema | | | (50) Absence or disturbance of the sense of smell | | |
| (b) Psoriasis | | | (51) Bed wetting | | |
| (c) Atopic dermatitis | | | (52) Absence or removal of the spleen, or rupture or tear of the spleen without removal | | |
| (17) Irregular heartbeat, including abnormally rapid or slow heart rates | | | (53) Evaluation, treatment, or hospitalization for alcohol abuse, dependence, or addiction | | |
| (18) Allergic to bee, wasp, or other insect stings | | | (54) Anorexia or other eating disorder | | |
| (19) Heart murmur, valve problem or mitral valve prolapse | | | (55) Taken medication, drugs, or any substance to improve attention, behavior, or physical performance | | |
| (20) Allergic to wool | | | (56) Cracked bone or fracture(s) | | |
| (21) Heart surgery | | | (57) Bursitis | | |
| (22) Any other heart problems | | | (58) Do you smoke? (If yes :) | | |
| (23) High blood pressure | | | (a) Type- Cigarettes, Cigars, Smokeless tobacco | | |
| (24) Ulcer (stomach, duodenum or other part of intestine) | | | (b) How many per day? | | |
| (25) Intestinal obstruction (locked bowels), or any other chronic or recurrent intestinal problem, including small intestine or colon | | | (c) Date last used | | |
| (26) Detached retina or surgery for a detached retina | | | (59) Braces/Retainers | | |
| (27) Surgery to remove a portion of the intestine (other than the appendix) | | | (60) Evaluation, treatment, or hospitalization for substance use, abuse, addiction or dependence (including illegal drugs, prescription medications, or other substances) | | |
| (28) Any other eye condition, injury or surgery | | | (61) Loss of finger, toe or part thereof | | |
| (29) Gall bladder trouble or gall stones | | | (62) Loss of the ability to fully flex (bend) or fully extend a finger, toe or other joint | | |

Medical Survey

Please click the box with your answer. Left Box is "Yes," Right Box is "No."

| | | | | | |
|--|--|--|--|--|--|
| (30) Jaundice | | | | | |
| (31) Missing a kidney | | | (63) Any illnesses, surgery, or hospitalization not listed above | | |
| (32) Allergy to common food (milk, bread, eggs, meat, fish or other common food) | | | (64) Broken bone requiring surgery to repair (with or without pins) | | |
| (33) (Females only) Abnormal PAP smear or gynecological problem | | | (65) Ruptured or bulging disk in your back or surgery for a ruptured or bulging disk | | |
| Blank | | | (66) (Males only) Missing a testicle, testicular implant, or undescended testicle | | |

IF YOU ANSWERED “YES” TO ANY QUESTION ON THE MEDICAL HISTORY SURVEY, YOU MUST FULLY EXPLAIN WHY YOU MARKED “YES.” (See Example below.)

Write the number of the question and an explanation on the lines provided below.

Ex: 59—Braces/Retainers

I wore braces when I was 12 to correct my overbite.

Comments:

Mental Health Survey

VIRGINIA COMMONWEALTH CHALLENGE YOUTH ACADEMY

PURPOSE: This survey must be completed by parent (or guardian) /youth in order for the youth to participate in the 22 week residential program which utilizes a highly structured quasi-military format. Understandably youth will need to be able to withstand the physical and emotional stressors during their transition into the CCYA lifestyle. These questions are designed to determine if the youth has developed any condition, which would make it hazardous to participate in CCYA academic/athletic program. **"Yes" answers are not necessarily disqualifiers, rather they help provide information that allows the proper assistance to the youth.** Dishonesty or non-disclosure of mental health are disqualifiers and any future discovery of a non-disclosed or concealed mental health history will be grounds for immediate dismissal.

Candidate Name: _____

Have you ever been given a psychiatric /mental health diagnosis by a doctor or therapist (ex: ADHD, Depression, Bipolar, ODD, Anxiety etc)? Yes ☐ No ☐

if yes what was the diagnosis? _____

Have you ever received counseling before? ☐ Yes ☐ No From _____ to _____

What type of counseling have you received ? ☐ Counseling/therapy ☐ Rehab ☐ In-home Services ☐ Family Counseling

Brief description of services you received: _____

Have you ever harmed yourself intentionally? ☐ Yes ☐ No (if yes check all that apply) ☐ Burning/Cutting ☐ Suicidal thoughts ☐ Suicide Attempts

Other _____ When was the last time you intentionally harmed yourself? Date: _____

Do you have a history of drug, nicotine, recreation, street or pharmaceutical (not prescribed for you) Drug use? ☐ Yes ☐ No

(If yes) what drug have you used? _____

Have you experienced any significant trauma or abuse(ex; sexual, criminal, assault, or significant loss)? ☐ Yes ☐ No

(If YES please list triggers you have identified) _____

Have you ever had a psychiatric, behavior and or mental health Hospitalization? ☐ Yes ☐ No Dates _____ To _____

Name of Facility/ Hospital: _____ Reason for Hospitalization: _____

Are you currently prescribed, or previously prescribed (past 2 years) any medication from a physician, psychiatrist or nurse practitioner?

if so please list below: _____

IF YOU HAVE BEEN PREVIOUSLY HOSPITALIZED FOR MENTAL HEALTH REASONS, YOU MUST PROVIDE THE PSYCHOLOGICAL EVALUATION & DISCHARGE SUMMERY PAPERWORK AND FAX TO THE COUNSELING DEPT @ 757-491-3949

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the Candidate to penalties and/or termination as determined by CCYA.

Candidate Signature: _____ Parent/Guardian Signature: _____ Date: _____



Commonwealth ChalleNGe Youth Academy

Counseling Department

P: 757-491-5932 F: 757-491-5932

Informed Consent and Statement of Confidentiality

This is a statement to acknowledge that information you share with Commonwealth ChalleNGe Youth Academy (CCYA) will be managed within the legal and ethical conditions of confidentiality and in accordance with HIPAA, the Health Insurance Portability and Accountability Act. Information you disclose may not be shared with a third party outside of Commonwealth ChalleNGe Youth Academy (CCYA) without your written consent, except under the following conditions, outlined by the Commonwealth of Virginia and The American Counseling Association (ACA):

1. If a candidate/cadet communicates that he or she poses a life-threatening risk to him or herself or to someone else, appropriate parties in the community may need to be notified in order to prevent harm from occurring. Any troublesome signs of passive to active suicidal, homicidal ideation, or injury, to one's self or another person, may also require CCYA to need to contact local emergency services toward support of your candidate/cadet.
2. If any information is disclosed by the candidate/cadet which indicates the abuse of a minor or an elder, the Counseling Department of CCYA has a legal mandate to make a report to Child Protective Services, the Division of Social Services, or other relevant authorities.
3. If any legal action involving a candidate/cadet is cited within a subpoena, where a judge may legally compel the CCYA Counseling Department or one of its attending counselors to release information from the records of a candidate/cadet, then the CCYA Counseling Department would be required to need to disclose either the subpoenaed clinical file, or pertinent content from the file, to the court.
4. In the event of any malpractice action taken against the CCYA Counseling Department or a CCYA counselor, CCYA and/or the counselor will be able to provide all relevant and necessary client information to legal authorities, as evidence necessary to the counselor's defense.
5. The counselor also may seek confidential supervision with professional colleagues, as necessary, for maintaining standards of best-practice, toward supporting your candidate/cadet.
6. All case files are property of CCYA and the CCYA Counseling Department and are maintained within the mandatory security guidelines, as outlined by HIPAA, the laws of Virginia, and the ACA.

Please feel free to ask CCYA any questions regarding this Informed Consent and Confidentiality Statement and sign below to indicate that you understand this Informed Consent toward the clinical support and treatment of your candidate/cadet, as necessary, by the CCYA Counseling Department:

Candidate/Cadet Name

Date

Signature of Parent or Legal Guardian

Print Name



Commonwealth Challenge Youth Academy

Counseling Department

P: 757-491-5932 F: 757-491-5932

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

****Please note: If the cadet is 18 years or older, they must be the one to sign this form****

I, _____, with the date of birth, _____
Print Cadet Name *Date of Birth*

hereby authorize Commonwealth Challenge Youth Academy Counseling Department to request and/or disclose confidential records to the below-listed agency, person(s), or organization.

I understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to Commonwealth Challenge Counseling Department 253 C. Street, Camp Pendleton, Virginia Beach, VA 23451-2576.
Revocation is not effective as to health records already disclosed in accordance with this authorization.

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient, especially if the recipient is not a HIPPA-designated environment or entity.

I understand that I am entitled to receive a copy of this authorization if requested.

Description of Information to be Available: *(Client and/or Clinical Provider, please check any items to be eligible for disclosure)*

| | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Psychological/Clinical Assessment | <input type="checkbox"/> Discharge/Transfer Summary | <input type="checkbox"/> ALL Records |
| <input type="checkbox"/> Diagnoses | <input type="checkbox"/> Coordination of Care Information | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Past Progress/Treatment Notes | _____ |
| <input type="checkbox"/> Treatment Plan/Summary | <input type="checkbox"/> Medication/Med Management Information | _____ |
| <input type="checkbox"/> Current Treatment Update | <input type="checkbox"/> Mental Health Professional Recommendations | _____ |

Disclosure/Request of Information can be provided to the following Agency, Organization, or Individual listed below:

Name: _____

Phone Number: _____ Fax Number: _____

Address: _____

This authorization will expire 90 days post-graduation/termination from the program unless otherwise specified below:

___ / ___ / ___

Signature of Cadet

Date

Signature of Parent, Guardian, or Legal Custodian

Date

Print Name of Parent, Guardian, or Legal Custodian