Commonwealth Challenge Application
(Part One and Part Two)

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), or mail the application. After we receive the complete Part One, we will email you Part 3 of the application.**

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) (If Applicable)
- 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.

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 (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)

Data Protected by The Privacy Act of 1974

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.**
- **Willing to be FREE from the illegal use of drugs or substances, alcohol, and tobacco products.**
- **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 _____ Middle Name _____ First Name _____

SSN _____ D.O.B MM/DD/YY _____ AGE _____ SEX M / F _____

Address _____ City _____ State _____ Zip Code _____

Ethnicity/Race *Please click the box with your answer*

☐ Hispanic/Latino ☐ American Indian ☐ Asian ☐ African American ☐ Caucasian ☐ Native Hawaiian

☐ Alaska Native ☐ Pacific Islander ☐ Other _____

Height (inches) _____ Weight _____ Hair Color _____ Eye Color _____

Shirt: _____ Pants: _____ Shoe Size _____

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 bein 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
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? _____

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

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

6. Are you currently on probation? YES ☐ NO ☐ for how long? _____
   a. Who is your probation officer: _____
   b. What is your probation officer's phone number: _____

7. 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: _____

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? _____

_____

- ☐ Grade transcripts
- ☐ Standardized test records
- ☐ Special Education evaluation (if applicable)
- ☐ Withdrawal/Transfer form
- ☐ Individual Education Plans (IEP) / 504Plan (if applicable)
- ☐ Tri-annual reviews
- ☐ Social history
- ☐ 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).

- ☐ English 9 (A or B)
- ☐ English 10 (A or B)
- ☐ English 11 (A or B)
- ☐ English 12 (A or B)
- ☐ Earth Science (A or B)
- ☐ Biology I (A or B)
- ☐ Biology II-Ecology
- ☐ Chemistry (A or B)
- ☐ Economics & Personal Finance(A or B)
- ☐ Algebra I (A or B)
- ☐ Algebra II (A or B)
- ☐ Algebra Functions & Data Analysis (A or B)
- ☐ Geometry (A or B)
- ☐ World History & Geography I (A or B)
- ☐ World History & Geography II (A or B)
- ☐ VA/US History (A or B)
- ☐ VA/US Government (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 forma**t. **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:

Commonwealth ChalleNGe Youth Academy
Clinical Counseling Department
Admissions Fax: (757) 491-2146

MENTAL HEALTH APPLICATION SECTION

Dear CCYA Applicant and Parents/Guardians,

The following forms are required to be completed to ensure the safety and mental health stability for your Applicant's attendance at Commonwealth ChalleNGe Youth Academy. Please read the following information carefully and respond honestly in the questionnaire.

Mental Health Criteria for Academy Admission:

1. *The applicant has not been psychiatrically hospitalized withinin the past 6 months.*
2. *The applicant has not resided in an in-patient facility in the past 6 months (to include, but not limited to: facilities for addiction treatment; suicidal/homicidal intention; or other mental health diagnoses.)*
3. *The applicant is not required to attend outpatient telehealth meetings more than twice a month.*

Please use the checklist below to ensure all Mental Health paperwork is completed for the applicant to be considered for acceptance into the Commonwealth ChalleNGe Youth Academy:

ALL applicants must complete the following:

- ☐ Mental Health Survey
- ☐ Informed Consent and Statement of Confidentiality
- ☐ Authorization for Release of Confidential Information
- ☐ Letters of Endorsement, ***if*** the applicant has a current behavioral/mental health provider(s), see below:

1. ***If your child is receiving CURRENT talk therapy sessions from a psychologist, counselor, social worker, or other mental health provider:***

- ☐ Provide a Letter of Endorsement from the current Mental Health Therapy Provider
- ☐ Not Applicable

2. ***If your child is receiving CURRENT psychiatric medication(s) from a psychiatrist, nurse practitioner, or Medical doctor (MD) for psychological or behavioral health issues:***

- ☐ Provide a Letter of Endorsement from the Psychiatric Medication Provider
- ☐ Not Applicable

3. ***If your child is receiving CURRENT mental health therapy from a licensed professional, does that provider recommend the applicant continue outpatient teletherapy while attending CCYA:***

- ☐ Yes (This can only be re-visited after 2 weeks of successful academy attendance.)
- ☐ Not Applicable

VIRGINIA COMMONWEALTH CHALLENGE YOUTH ACADEMY (CCYA)

Mental Health Survey

Purpose: This survey must be completed by a parent/guardian or applicant, if 18-years old. CCYA includes a 22-week residential phase which utilizes a highly structured, quasi-military format. The applicant will need to be able to manage the physical and emotional stressors during their transition to the residential lifestyle. The questions below can help determine if the applicant has any specific mental health or emotional stressors which might conflict with program participation. **"Yes" answers are not program disqualifiers, but rather help our staff to better support your applicant during the program. However, intentional non-disclosure or concealment of known mental health issues of the applicant can become grounds for potential dismissal after program admittance.**

Applicant Last Name, First Name: ______________________________ **Date of birth:** ____________________

1. 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? ______________________________

2. Have you ever received counseling? ☐ Yes ☐ No ***Dates :*** *(MM/YEAR)* **From:**____________**To:**____________

If YES, what type of counseling have you received ? ☐ *Counseling/therapy* ☐ *Rehab* ☐ *In-home Services* ☐ *Family Counseling*

Brief description of services you received: ______________________________

____

3. Have you ever harmed yourself intentionally? ☐ Yes, check all that apply ☐ *Burning/Cutting* ☐ *Suicidal thoughts* ☐ *Suicide Attempts*
☐ No

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

If YES, what drug(s) have you used? ______________________________

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

If YES, please briefly describe the incident and list any triggers you have identified: ______________________________

6. Have you ever been involved in a case reported to CPS? ☐ Yes ☐ No Approximate Date of Report:____________________

If YES, briefly describe the incident reported: ____________________ Outcome of report or investigation:____________________

7. Have you ever been hospitalized for psychiatric or behavioral issues? ☐ Yes ☐ No ***Dates :*** *(MM/YEAR)* ***From:*** ____________ ***To:***____________

If YES, Name of Facility/ Hospital:____________________ Reason for Hospitalization:____________________

***IF HOSPITALIZATION OCCURRED WITHIN THE LAST YEAR, YOU MUST PROVIDE THE PSYCHOLOGICAL EVALUATION & DISCHARGE SUMMARY. PLEASE FAX TO CCYA ADMISSIONS AT (757)491-2146**

8. Are you currently prescribed or previously prescribed (past 2 years) any psychiatric medication by a physician, psychiatrist, or nurse practitioner for mental health purposes? If YES, please list medication with dosage amount: ______________________________

9. Do you (Applicant) have a child/children? ☐ Yes ☐ No a. Do you (Applicant) have legal custody of your child/children? ☐ Yes ☐ No

b. How old is/are your child/children? __________ If NO, who has legal custody? ______________________________

c. Who will be caring for your child/children while you are attending CCYA? ______________________________

FOR FEMALE APPLICANTS ONLY

10. Have you ever been pregnant? ☐ Yes ☐ No If YES, provide the estimated date of your last pregnancy: ____________

Are you currently pregnant? ☐ Yes ☐ No ☐ Unknown

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, during the residential phase, to disciplinary action and/or program termination as determined by CCYA leadership.

Applicant Signature:______________________________ Date:______________

Parent/Guardian Signature:______________________________ Date:______________

CCYA Clinical Counseling Department
Work (757) 491-5932 ext. 232 Fax: (757) 491-3643
Email: clinicalcounselors@vachallenge.org

Statement of Confidentiality & Informed Consent to Treatment

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 (Health Insurance Portability and Accountability Act). Information you disclose may not be shared with a third party outside of CCYA without your written consent, except under the following conditions, outlined by the Commonwealth of Virginia:

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 Clinical 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 state, federal agency, or judge may legally compel the CCYA Counseling Department or one of its counselors to release information from the records of a candidate/cadet to the court, then the CCYA Counseling Department would be required to disclose either the subpoenaed clinical file or pertinent content from the file.
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. Clinical counseling staff counselors may seek confidential supervision with their Clinical Supervisor(s), as necessary, for maintaining standards of best-practices toward supporting your candidate/cadet.
6. Clinical counseling staff counselors will consult with professional colleagues, school administration, and campus staff, as indicated, toward supporting your candidate/cadet.
7. 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 (Affordable Care Act).

Your signature below indicates:

1. *You understand and agree with the Statement of Confidentiality*
2. *You are informed in understanding and agree that CCYA Clinical Counseling Dept. may provide crisis intervention & short-term clinical counseling treatment to your candidate/cadet while in residence at CCYA, as needed.*
3. *You understand that Clinical Counseling treatment works toward cadets' healthy student adjustment while in residence.*
4. *You understand that the Clinical Counseling Dept. accepts self-referrals from cadets and referrals from CCYA campus staff & academy administration for clinical counseling.*
5. *You understand that dual relationships for site counselors on a small campus can be unavoidable and that your cadet's site counselor may also need to serve as an outreach educator or GED proctor while your cadet is in residence at CCYA.*
6. *Your signature below provides us with your Informed Consent to Clinical Treatment of your cadet while at CCYA.*

_____ _____

Print Candidate/Cadet Name **Date**

_____ _____

Signature of Parent or Legal Guardian **Print Name of Parent or Legal Guardian**

Commonwealth ChalleNGe Youth Academy
Counseling Department
P: 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)*

___ Psychological/Clinical Assessment	___ Discharge/Transfer Summary	___ ALL Records
___ Diagnoses	___ Coordination of Care Information	___ Other: _____
___ Psychiatric Evaluation	___ Past Progress/Treatment Notes	_____
___ Treatment Plan/Summary	___ Medication/Med Management Information	_____
___ Current Treatment Update	___ 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

Application Phase Two (Medical)

To Continue your Child's Application Process, please complete the enclosed medical forms, and attach the required documents. The physical MUST be completed by a medical provider.

Once you have completed all requirements listed below, scan and email to admissions@vachallenge.org, mail or bring in to our office.

Please submit the documents in the order listed below:

- Physical Examination
- Authorization of Medical Care Form

Required Supporting Documents

- Copy of your child's Medical Insurance Card (front and back)
- Copy of your child's valid ID card (DMV issued ID, Passport, or military dependent ID)
- Copy of your child's Immunization Record
- Copy of your child's TB Skin Test (PPD)/Chest X-Ray result (must be completed within 12 months of enrollment at Challenge. NO TB RISK ASSESSMENTS. YOU MUST SUBMIT THE ACTUAL SKIN TEST/X-RAY RESULT)

From the date you receive Phase Two of the Application, you have three (3) weeks to complete the requirements and submit, or your child will be placed on a waiting list until complete

Once we have received all paperwork from Phase One and Phase Two of the application, and determine your child is eligible for Challenge, they will be invited to Challenge Pre-Inprocessing to complete the acceptance process.

VIRGINIA COMMONWEALTH CHALLENGE YOUTH ACADEMY

PHYSICAL EXAMINATION: To be completed by Medical Provider

Patient's Full Name				Age	Vision		
						Uncorrected	Corrected
Weight	*Build*	*Temperature:*	*BP/Arm/Pos*		Far	R 20/ B20/	R 20/ B20/
						L 20/	L 20/
Height	*Resp*	Pulse Before Exercise			Near	R 20/ B20/	R 20/ B20/
		Pulse After Exercise				L 20/	L 20/

Clinical Evaluation

	Normal	Abnormal	Not Done		Normal	Abnormal	Not Done
1 - Head, Face, Neck, Scalp				14 - Anus and Rectum			
2 - Nose				15 - Endocrine System			
3 - Sinuses				16 -G - U System			
4 - Mouth and Throat				17 - Hernia			
5 - Ears				18 - Upper Extremities			
6 - Eyes - General				19 - Feet			
7 - Ophthalmoscopic				20 - Lower Extremities (include knee jerks)			
8 - Pupils (equality and reaction)				21 - Spine Other Musculoskeletal			
9 - Ocular Motility				22 - Identifying Body Marks, Scars			
10 - Lungs and Chest (include breast)				23 - Skin			
11 - Heart (thrust, size, rhythm, sounds)				24 - Neurologic (include Rhomberg)			
12 - Vascular System				25 - Psychiatric			
13 - Abdomen and Viscera				26 - Pelvic (females only)			

Describe Abnormal Finding In Detail

Physician's Recommendation for Participation in the Virginia Commonwealth Challenge Youth Program:
Check one:

☐ Cadet is cleared for partificpation with NO Restrictions

☐ Cadet is Cleared for partifipcation with Restrictions, explain: _____

☐ Cadet is NOT cleared for particiation, explain _____

Additional Comments: _____

Physician's Signature: _____ Physician's Printed Name _____ Date: _____

REQUIRED Physicians Office Stamp or Information

COMMONWEALTH CHALLENGE YOUTH ACADEMY

Authorization of Medical Care

Cadet Last Name:	**Cadet First Name:**	**MI:**	**DOB:**

Custodial Parent(s): I/We the parent(s)/guardian(s) of above Cadet who is enrolling in the Commonwealth Challenge Youth Academy. hereby appoint CCYA, my true and lawful attorney in fact, to act in my name, place and stead, in the event that I am unavailable and a decision must be made and/or authorization given for the above named child regarding medical treatment, education matters, participation in religious or recreational activities or in any other matters involving my child. I authorize CCYA in this event to take any and all steps, as fully and for all intents and purposes as I might do or could do if personally present. I understand that pursuant to the statute this power of attorney terminates six months from the date executed.

In the event of any illness or injury, reasonable efforts will be made to immediately notify me/us. I further understand that upon request by Challenge's medical department, I will be available and responsible for transporting my child for medical appointments and/or non-emergent care.

Treating Physician: The above name individual is enrolling in the Commonwealth Challenge Youth Academy, which is a five ½-month program. As the authorized treating physician, please outline any and all prescription and over the counter medications that can be dispensed to the cadet. So that the medication schedule is not interrupted, please identify the period the medication must be dispensed and when applicable, provide enough refill medication to cover the duration of the program.

Medication Name	**Mg**	**Dose**	**Freq**	**Dispense Schedule**	**Reason**
				AM / PM / HS / O	

Primary insurance company	**Policy Number**	**Phone Number**

Comments:_____

_____

Parent/Guardian Name	Signature	Date: Phone
Physician Name	Signature	Date Phone: