



Discovery ChalleNGe Academy - Report of Medical History and Insurance Information

1. Student Name: _____ CA ID#: _____ Birth Date _____ Height _____ Weight _____
2. Parent/ Guardian Name: _____ Parent/ Guardian Contact Number: _____
3. Statement of Health- Good Fair Poor Explain: _____
4. Have you ever been hospitalized? Yes No For What? _____ When? _____
5. Do you normally go to the Doctor for headaches, colds, or minor ailments? Yes No
6. Current Medications _____ Reason _____
7. Allergies (List should include insect bites and stings, common foods, and medications) _____
8. Your Doctor's Name _____ Phone# _____ 24 hr. # _____
9. Do you wear braces? Yes No Do you wear contact lenses? Yes No
10. Have you been hospitalized in the last 6 months? _____ For What? _____
11. Have you had a broken bone in the last 6 months? _____ What happened? _____
12. Are you under a Doctor's care for ANY condition, or diagnosis or prescribed medication? _____

NOTE: If you answered "Yes" to question 9, 10, or 11, you must include a "Doctor's Release" stating that you are emotionally and physically capable to participate in all components of the program. A physical exam and release is required for accepted students.

CIRCLE ALL OF THE ITEMS THAT APPLY NOW OR THAT YOU HAVE EVER EXPERIENCED. IF YOU CIRCLE ANY ITEM, PUT THE YEAR THAT THE CONDITION OCCURRED NEXT TO THE CONDITION, AND A BRIEF EXPLANATION BELOW IT.

If this is a current condition, write CURRENT next to the condition. Failure to disclose known issues could result in expulsion of student.

- | | | | |
|-----------------------------------|-------------------------------|-----------------------------|--|
| Eye, ear, nose, or throat trouble | Frequent indigestion | Pregnant at this time | Paralysis (include infantile) |
| Chronic or frequent colds/coughs | Stomach, liver, or intestinal | Treated for female disorder | Epilepsy, seizures, or fits |
| Severe tooth or gum trouble | Gall bladder trouble | Change in menstrual cycle | Motion sickness |
| Bleeds easily | Arthritis, rheumatism | Recent gain/loss of weight | Frequent trouble sleeping |
| Liver disorder/disease | Diabetes or Hypoglycemia | Had 1 or more children | Eating Disorder |
| Nose bleeds | Jaundice or hepatitis | Unconsciousness/Head Injury | Depression or heavy weeping |
| Skin disorders | Bone, joint or deformity | Thyroid trouble or goiter | Loss of memory or amnesia |
| Sinusitis, hay fever | Tumor, growth, cyst, cancer | Lameness or neuritis | Nervous disorder |
| Asthma, shortness of breath | Rupture/hernia | Broken Bones | Adverse reaction to medication |
| Coughed up blood | Anemia | Sickle Cell | Rectal disorder |
| Tuberculosis | Painful/frequent urination | recurrent back pain | Head Lice |
| Sleepwalker | Scarlet/ Rheumatic fever | Bedwetting since age 12 | Swollen or painful joints |
| Dizziness or fainting spells | Palpitation or pounding heart | Leg or feet cramps | Kidney stone/ blood in urine |
| Frequent or severe headaches | Heart trouble or murmur | Sugar or albumin in urine | Loss of finger, toe, arm, or leg |
| High or low Blood Pressure | Sexually Transmitted Disease | Knee brace or back support | Painful or "trick" knee, shoulder, elbow |
| Attempted suicide | | | |

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER (Must be MD, DO, PA, NP) _____

SIGNATURE OF PHYSICIAN OR EXAMINER _____ DATE _____

I, _____ parent/guardian of _____ hereby agree to:
 (Printed Name of Parent) (Printed Name of Student)

1. Maintain active health insurance for the entire duration of the academy.
2. Ensure that all required vaccinations are up to date, in accordance to the academy's specifications, prior to the Academy's start date.
3. Provide \$40 on intake day to cover any miscellaneous medical expenses.

→ Signature of Parent/Guardian _____ Signature of Parent/Guardian _____

→ Student Signature _____



Sports Physical Form (SF 93) Page 1 of 2

NOTE: This information is for official and medically-confidential use only and will not be released to unauthorized persons

1. NAME OF EXAMINEE (Student) (Last, first, middle)			2. CALIFORNIA ID#	3. DOB	DATE OF EXAM:
4a. HOME STREET ADDRESS(Street, City, State, ZIP)			5. EXAMINING FACILITY (STAMP HERE)		
4b. CITY	4c. STATE	4d. ZIP CODE			
6. PURPOSE OF EXAMINATION					

SPORTS PHYSICAL FOR APPLICATION TO ATTEND DISCOVERY CHALLENGE ACADEMY AND IMMUNIZATION UPDATE REQUIRED.

7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED(Use additional pages if necessary)			
a. PRESENT HEALTH	b. CURRENT MEDICATION	REGULAR OR INTERM.	ROUTE
c. ALLERGIES(Include insect bites/stings and common foods)			
	d. HEIGHT	e. WEIGHT	
8. PATIENT'S OCCUPATION		9. ARE YOU (check one)	
STUDENT		<input type="checkbox"/> RIGHT HANDED <input type="checkbox"/> LEFT HANDED	

10. PAST/CURRENT MEDICAL HISTORY											
CHECK EACH ITEM. IF "YES" EXPLAIN IN BLANK SPACE ON 2ND PAGE. LIST EXPLANATION BY ITEM NUMBER											
CHECK EACH ITEM	YES	NO	YEAR	CHECK EACH ITEM	YES	NO	YEAR	CHECK EACH ITEM	YES	NO	YEAR
Household contact with anyone with tuberculosis				Shortness of breath				Bone, joint or other deformity			
Tuberculosis or positive TB test				Pain or pressure in chest				Loss of finger or toe			
Blood in sputum or when Coughing				Chronic cough				Painful or "trick" shoulder or elbow			
Excessive bleeding after injury or dental work				Palpitation or pounding heart				Recurrent back pain or any back injury			
Suicide attempt or plans				Heart trouble				"Trick" or locked knee			
Sleepwalking				High or low blood pressure				Foot trouble			
Wear corrective lenses				Cramps in your legs				Nerve injury			
Eye surgery to correct vision				Frequent indigestion				Paralysis (including infantile)			
Lack vision in either eye				Stomach, liver or intestinal				Epilepsy or seizure			
Wear a hearing aid				Gall bladder trouble or gallstones				Car, train, sea or air sickness			
Stutter or stammer				Jaundice or hepatitis				Frequent trouble sleeping			
Wear a brace or back support				Broken bones				Depression or excessive worry			
Scarlet fever				Adverse reaction to medicine				Loss of memory or amnesia			
Rheumatic fever				Skin diseases				Nervous trouble of any sort			
Swollen or painful joints				Tumor, growth, cyst, cancer				Periods of unconsciousness			
Frequent or severe headaches				Hernia				Parent/sibling with diabetes, cancer, stroke or heart disease			
Dizziness or fainting spells				Hemorrhoids or rectal disease				X-ray or other radiation therapy			
Eye trouble				Frequent or painful urination				Chemotherapy			
Hearing loss				Bed wetting since age 12				Head Lice			
Recurrent ear infections				Kidney stone or blood in urine				Plate, pin or rod in any bone			
Chronic or frequent colds				Sugar or albumin in urine				Easy fatigability			
Severe tooth or gum trouble				Sexually transmitted diseases				Been told to cut down or criticized for alcohol use			
Sinusitis				Recent gain or loss of weight				Used illegal substances			
Hay fever or allergic rhinitis				Eating disorder (anorexia, bulimia, etc...)				Used tobacco			
Head injury				Arthritis, Rheumatism, or Bursitis							
Asthma				Thyroid trouble or goiter							



Sports Physical Form (SF 93) Page 2 of 2

11. FEMALES ONLY

CHECK EACH ITEM	YES	NO	DON'T KNOW	DATE OF LAST MENSTRUAL PERIOD	DATE OF LAST PAP SMEAR	
Treated for a female disorder						
Change in menstrual pattern						

Pregnancy exam must be conducted. Results - Negative Positive

	YES	NO	
12. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details)			If you answered "yes" to any questions on page 1, use the space below to explain:
13. Have you had, or have you been advised to have, any operation? (If yes, describe and give age at which occurred)			
14. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital)			
15. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the last 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic and details)			
16. Have you ever been diagnosed with a learning disability? (If yes, give type, where and how diagnosed)			

17. ADDITIONAL INFORMATION BELOW:

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

18a. TYPED OR PRINTED NAME OF EXAMINEE (STUDENT)	18b. SIGNATURE	18c. DATE
--	----------------	-----------

19. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physician shall comment on all positive answers. Physician may develop by interview any additional medical history deemed important, and record any significant findings here.)

If History Of Asthma, is Inhaler Needed **Yes** **No** **N/A**

20a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER (Must be MD, DO, PA, NP)	20b. SIGNATURE	20c. DATE
--	----------------	-----------



Behavioral Health Requirement

IF APPLICABLE, PLEASE PRESENT THIS FORM TO YOUR THERAPIST/PSYCHIATRIST IN ORDER FOR THEM TO ASSIST YOU IN SECURING THE DOCUMENTS NEEDED TO BE CONSIDERED FOR THE DISCOVERY CHALLENGE ACADEMY.

Note to Students: Make (2) copies of **ALL** required documents or application will **NOT** be reviewed.

The client presenting this letter is now “**applying**” to the Discovery ChalleNGe Academy Program and the on-site high school for a period of 5 ½ months (July-Dec. or Jan-June). This is an intervention and will be a temporary school assignment for students 16-18 years of age. **(Receipt of these documents does not mean the Student is accepted, at this time).**

Please provide the client with a letter completely detailing *each* of the requirements listed below so that he/she can turn it in as part of their application.

- Client’s current diagnosis
- Client’s former diagnosis (es), if applicable
- Treatment plan for client (to include: frequency of sessions, goals, client’s progress, etc.)
- Any corresponding psychiatric services (to include: Psychiatrist’s name/contact information, current medications and dosage, history of medication management/client’s responsiveness to medication, etc.)
- Treating Therapist/Psychiatrist’s professional opinion on the mental/emotional stability of the client and his/her ability to complete this program (Note: this program is a 5 ½ month, quasi-military structured program, with strict adherence to discipline/rules/order and encompasses a high stress environment).

*Note: If the client has ever been admitted to a hospital for behavioral health reasons, a complete psychological evaluation from the time of the hospitalization will be required **IN ADDITION TO** the letter provided by the current treating Therapist/Psychiatrist.

If you have any questions or need clarification regarding the Academy review process related to behavioral health only, please contact someone in the counseling department (916) 855-4010.

Sincerely,

Counseling Department
916-855-4010
Discovery ChalleNGe Academy
P.O. Box 1189
Lathrop, CA 95330-1189