# 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** _____

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**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

**STUDENT**

9. ARE YOU (check one)

☐ RIGHT HANDED ☐ 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 | | | | Shortness of breath | | | | Bone, joint or other deformity | | | |
| anyone with tuberculosis | | | | Pain or pressure in chest | | | | Loss of finger or toe | | | |
| Tuberculosis or positive TB test | | | | Chronic cough | | | | Painful or "trick" shoulder | | | |
| Blood in sputum or when | | | | Palpitation or pounding heart | | | | or elbow | | | |
| Coughing | | | | Heart trouble | | | | Recurrent back pain or any | | | |
| Excessive bleeding after injury | | | | High or low blood pressure | | | | back injury | | | |
| or dental work | | | | Cramps in your legs | | | | "Trick" or locked knee | | | |
| Suicide attempt or plans | | | | Frequent indigestion | | | | Foot trouble | | | |
| Sleepwalking | | | | Stomach, liver or intestinal | | | | Nerve injury | | | |
| Wear corrective lenses | | | | Gall bladder trouble or | | | | Paralysis (including infantile) | | | |
| Eye surgery to correct vision | | | | gallstones | | | | Epilepsy or seizure | | | |
| Lack vision in either eye | | | | Jaundice or hepatitis | | | | Car, train, sea or air sickness | | | |
| Wear a hearing aid | | | | Broken bones | | | | Frequent trouble sleeping | | | |
| Stutter or stammer | | | | Adverse reaction to medicine | | | | Depression or excessive worry | | | |
| Wear a brace or back support | | | | Skin diseases | | | | Loss of memory or amnesia | | | |
| Scarlet fever | | | | Tumor, growth, cyst, cancer | | | | Nervous trouble of any sort | | | |
| Rheumatic fever | | | | Hernia | | | | Periods of unconsciousness | | | |
| Swollen or painful joints | | | | Hemorrhoids or rectal disease | | | | Parent/sibling with diabetes, | | | |
| Frequent or severe headaches | | | | Frequent or painful urination | | | | cancer, stroke or heart disease | | | |
| Dizziness or fainting spells | | | | Bed wetting since age 12 | | | | X-ray or other radiation therapy | | | |
| Eye trouble | | | | Kidney stone or blood in urine | | | | Chemotherapy | | | |
| Hearing loss | | | | Sugar or albumin in urine | | | | Head Lice | | | |
| Recurrent ear infections | | | | Sexually transmitted diseases | | | | Plate, pin or rod in any bone | | | |
| Chronic or frequent colds | | | | Recent gain or loss of weight | | | | Easy fatigability | | | |
| Severe tooth or gum trouble | | | | Eating disorder (anorexia, | | | | Been told to cut down or | | | |
| Sinusitis | | | | bulimia, etc...) | | | | criticized for alcohol use | | | |
| Hay fever or allergic rhinitis | | | | Arthritis, Rheumatism, or | | | | Used illegal substances | | | |
| Head injury | | | | Bursitis | | | | Used tobacco | | | |
| Asthma | | | | Thyroid trouble or goiter | | | | | | | |

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| 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) | | |
| **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) | | |

**If you answered "yes" to any questions on page 1, use the space below to explain:**

17. ADDTIONAL INFORMAITON 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.)**

**Candidate will be participating in daily physical training exercises such as: pushups, sit-ups, short distance running (normally under 2 miles), extended hiking, and other basic exercises. Is the patient able to participate in these exercises without limitation?**

CLEARANCE

☐ Cleared ☐ Not cleared (reason)_____

☐ Cleared after completing evaluation/rehabilitation for: _____

**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 Challe***NG***e 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) 616-6033.

Sincerely,
Counseling Department
916-616-6033 & 916-616-7932
Discovery Challe***NG***e Academy
P.O. Box 1189
Lathrop, CA 95330-1189