Interview Date: _____

Interview Time: _____

Location:
700 E. Roth Rd
Lathrop CA, 95330
916-616-7364

Discovery ChalleNGe Academy

Document Checklist

Applicant:

The following documents will need to be turned at the time of your interview. If you are unable to gather all documents, we will NOT be able to process the application until all documents are turned in. You may turn in any documents by emailing them to admissions@iamdiscovery.org or by uploading them at www.iamdiscovery.org/upload.

- ☐ **Online Application**
- ☐ **Custody Documents (If Applicable)**
- ☐ **Copy of Birth Certificate**
- ☐ **Copy of Social Security Card or Receipt**
- ☐ **Copy of California ID or Receipt**
- ☐ **Legal Supporting Documents, Ex. Police Report, ticket, court dates etc. (If Applicable)**
- ☐ **School Transcripts**
- ☐ **IEP / 504 (If Applicable)**
- ☐ **Copy of Health Insurance Card**
- ☐ **Sports Physical/SF 93 (Signed and Stamped by Dr., RN, PA, No Chiropractors)**
- ☐ **Therapist/Psychiatrist Clearance Letter (If Applicable)**
- ☐ **Immunization Records**
- ☐ **Tdap (Adacel within 10 Years)**
- ☐ **HPV Shot (Males and Females, Must Begin Series)**
- ☐ **MCV4 Shot (Within 5 Years) Booster shot required if Menactra shot was received before age 16**
- ☐ **TB Test with Results (Must be within 1 year of class start date)**
- ☐ **FLU Shot (January Class Only)**
- ☐ **Copy of Power of Attorney (Notarized)**

If you have any questions, please contact the admissions department at admissions@iamdiscovery.org or by phone at 916-616-7364

Sports Physical Form (SF 93) Page 1 of 3

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			

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 $50 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 2 of 3

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)			**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. 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?

◯ **Cleared**
◯ **Cleared after completing evaluation/rehabilitation for:**_____
◯ **Not cleared (reason):** _____

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
★		

TB Test Result Form

Name: _____

DOB:_____SEX: Male / Female

To be completed by the Physician:
Name of MD who read the exam (please print): _____

Date TB test was administered: _____

Date TB test result was read:_____

Result of Test: MM Induration: _____

Does Patient need a chest x-ray? _____Yes _____No

Signature of MD who read the exam: _____

Date:_____

MD Address:_____MD Phone Number: _____
_____
_____

Please Attach Form Here if taken within the last 12 months:

Note: Your physician's office may use its own TB test form to report the results, or you may be submitting results from a TB test administered within the last twelve (12) months. If so, please attach that documentation. Please indicate dates when the test was administered and read.

Discovery ChalleNGe Academy

Special Power of Attorney for the Authorization of Medical Care and Medical Expense Statement
THIS FORM NEEDS TO BE NOTARIZED

KNOWN ALL MEN/WOMEN BY THESE PRESENTS:

That I_____, Date of birth ___/___/____ ID # _____
Guardian (or Student if 18 years old) *(Guardian's, or Student's if 18 years old, CA ID #/Residency Card #)*

Am a legal resident of_____ County, California, hereby appoint the director of Discovery
(Name of County)
ChalleNGe Academy, located at Sharpe Army Depot, Lathrop, CA, as my true and lawful attorney-in-fact to do the following in my name and in my behalf:
Anything necessary to maintain (my health) the health of my child*, _____. I want my attorney-in-fact to
***If 18 years old enter "N/A".**
Have the power to consent to any medical or dental treatment needed for my child and to sign any papers needed to authorize those treatments. I want my attorney-in-fact to be able to do anything I could do if I were personally present. Anything my attorney-in-fact does to maintain the health of my child (my health) will be the same as if I had done it myself. This is a Durable Power of Attorney. It will stay in effect if I become disabled, incapacitated or incompetent. This Power of Attorney shall expire after the 22 week residential phase is completed or the Cadet withdraws or is terminated from the Academy.

Medical Expenses Statement of Understanding

The medical staff at the Discovery ChalleNGe Academy consists of a Medical Doctor, P.A, and RNs. They will make all necessary medical determinations regarding current cadets. Discovery ChalleNGe Academy **DOES NOT** pay for normal medical expenses incurred by your cadet. The cadet, and ultimately the parent/guardian, regardless of insurance coverage, is responsible for all normal medical and dental expenses, to include all co-payments, deductibles, and all non-covered charges. The Academy will provide physician, hospital, or pharmacy needs with the appropriate insurance information or Medical or Medicaid coverage.

IN WITNESS WHEREOF, I have affixed my signature hereto this_____day of _____20_____

Signature_____
Guardian (or Student if 18 years old)

********** TO BE COMPLETED BY NOTARY **********

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

STATE OF CALIFORNIA, COUNTY OF _____)

On _____before me, _____,

personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity (ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature: _____ **(Seal)**