



Additional Documents for Applicants Please complete the following documents and submit to the WYA Admission Department. Your application is not complete until all documents have been received. Documents can be submitted by email or fax. Please see submission instructions.

Medical Application. Instruction page and Medical pages 1-14.

Items in red can be returned without professional signature.

- Medical-1 Self Reporting Med History
- Medical-2 Physical Exam
- Medical-3 Physical Exam
- Medical-4 Request for Special Dietary
- Medical-5 Over the Counter
- Medical-6 Medications
- **Medical-8 Immunizations – must be on WYA form and signed in 2 places by the parent**
- **Medical-9 Behavior Health Questionnaire**
- **Medical-10 Behavior Health Provider Letter**
- Medical-11 Dental Exam
- **Medical-12/13 Limited Medical Services**
- **Medical-14 Information Release**
- **Medical Cards-front and back copy**

Authorization to Release of Information. In processing your application, there may be a need to confirm or clarify personal information you've provided with an outside agency. This form authorizes us to contact those agencies and exchange information, if necessary, to properly review and evaluate your application.

Applicant Personal Statement. This is your opportunity to tell us why you want to be considered for admissions. Please see the attached document for the writing prompt. You may use the document to write your statement or you may type it on a separate document.

Washington Youth Academy
Admissions Department
1207 Carver St. Bremerton, WA 98312
Toll Free (877) 228-8947 FAX (360) 473-2623
WYA.Applications@mil.wa.gov

DREAM BELIEVE ACHIEVE

The Washington Youth Academy Stresses Eight Core Components

~ Academic Excellence ~ Leadership and Followership ~ Life Coping Skills ~ Job Skills ~ Service to Community ~ ~ Responsible Citizenship ~ Health and Hygiene ~ Physical Fitness ~

WASHINGTON YOUTH ACADEMY



Today's ChalleNGe...Tomorrow's Success

MEDICAL APPLICATION INSTRUCTIONS

The medical application is a very important part of the admissions process. It requires the applicant to follow specific directions and to complete all pages with honesty and integrity.

The applicant will take the ENTIRE MEDICAL APPLICATION to the doctor for the physical exam. The doctor will review the answers that the Applicant provides on Medical-1, prior to the exam.

The chart below explains who should be completing and signing each form.

| Complete √ | Pages | Who completes the form. | Who signs the form. |
|--------------------------|------------|------------------------------|------------------------------------|
| <input type="checkbox"/> | Medical-1 | Applicant | Doctor, Applicant, Parent/Guardian |
| <input type="checkbox"/> | Med-2 & 3 | Doctor | Doctor |
| <input type="checkbox"/> | Medical-4 | Doctor and Applicant | Doctor, Parent/Guardian |
| <input type="checkbox"/> | Medical-5 | Doctor | Doctor |
| <input type="checkbox"/> | Medical-6 | Doctor and Applicant | Doctor, Applicant, Parent/Guardian |
| <input type="checkbox"/> | Medical-8 | Applicant or Parent/Guardian | Parent/Guardian |
| <input type="checkbox"/> | Medical-9 | Applicant | Applicant, Parent/Guardian |
| <input type="checkbox"/> | Medical 11 | Dentist | Dentist |
| <input type="checkbox"/> | Medical-13 | Applicant or Parent/Guardian | Parent/Guardian |
| <input type="checkbox"/> | Medical-14 | Applicant or Parent/Guardian | Applicant and Parent/Guardian |

The application is complete when all questions are answered and pages are signed.



Medical Application



Applicant's Self-Reporting Medical History

Please use additional pages as needed for explanations.

| | |
|-----------------------|--------------------|
| Applicant Legal Name: | Date of Birth: / / |
|-----------------------|--------------------|

| | | |
|--|------------------------------|-----------------------------|
| 1. Have you been hospitalized overnight in the past 5 years? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If "YES" explain | | |
| 2. Have you had surgery in the past 5 years? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If "YES" explain | | |
| 3. Are you missing any paired organs (kidney, lung, testicle?) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If "YES" explain | | |
| 4. Have you ever passed out during exercise? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If "YES" explain | | |
| 5. Have you had a head injury in the past 5 years? (Concussion or unconsciousness) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If "YES" how many times? | | |
| When was the last time? | | |
| How severe was each one? | | |
| 6. Are you currently using any prescription medications, pills or inhalers? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If "YES" explain | | |
| 7. Have you ever had heat exhaustion, heat stroke and/or heat cramps? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If "YES" explain | | |
| 8. Have you ever had numbness, tingling in your arms, hands, legs or feet? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If "YES" explain | | |
| 9. Have you attempted suicide within the last 12 months? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If "YES" explain | | |
| If "YES", have you participated in any behavior health services because of that attempt? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 10. Have you ever been diagnosed with ADD or ADHD? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If "YES" explain | | |
| 11. Do you have a history of violent outbursts and/or difficulty managing your anger? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If "YES" explain | | |

| | |
|---|-------------|
| By signing below, you ensure to the best of your knowledge, all information provided is true and accurate. | |
| Applicant Signature | Date |
| Parent/Legal Guardian Signature | Date |

| | | |
|--|---|------|
| I have reviewed the answers given by the Applicant. | | |
| Physician's Signature | X | Date |
| Physician's Printed Name | X | / / |



Medical Application

Sports Physical Form - MUST BE WITHIN 1 YEAR OF ENTRY



Physicians Please Note

The WYA is a 5½ month residential program that conducts rigorous physical training daily. Our physical training program is taken directly from the US Army Physical Training manual. Our focus is on 3 stages of exercise: toughening, conditioning and sustainment. Applicants will run several times a week, and develop muscular strength and endurance through calisthenics and cross-fit exercise.

Applicant LEGAL NAME:

| | | |
|-------|--------|---------|
| Last: | First: | Middle: |
|-------|--------|---------|

Applicant Address (Street, City, State, Zip)

Date of Birth

| Date of Exam | Height | Weight | Present Health |
|--------------|--------|--------|--|
| | | | Good <input type="checkbox"/> Average <input type="checkbox"/> Poor <input type="checkbox"/> |

Allergies (include medications, insect bites/stings, common foods, latex, pollen...)

Anaphylactic Food Reaction or Lactose Intolerance

| Current Medications | Regular or Intermittent | How Administered |
|---------------------|-------------------------|------------------|
| | | |
| | | |
| | | |
| | | |

Physical Exam and Medical History

CHECK EACH ITEM. IF "YES" add the age of occurrence/onset and explain on page **Medical-3**.

| | Yes | No | Age | | Yes | No | Age |
|-----------------------------------|-----|----|-----|--------------------------------|-----|----|-----|
| Adverse reaction to medicine | | | | Frequent or severe headaches | | | |
| Alcohol use | | | | Frequent trouble sleeping | | | |
| Arthritis, rheumatism or bursitis | | | | Frequent/painful urination | | | |
| Asthma | | | | Gall bladder problems | | | |
| Bacterial/viral infection | | | | Hay fever or allergic rhinitis | | | |
| Bed wetting since age 12 | | | | Head injury | | | |
| Blood in sputum | | | | Head Lice | | | |
| Bone, joint or other deformity | | | | Hearing loss | | | |
| Broken bones | | | | Heart trouble or murmur | | | |
| Chemotherapy | | | | Hemorrhoids/rectal disease | | | |
| Chronic coughing | | | | Hernia | | | |
| Chronic or frequent colds | | | | High or low blood pressure | | | |
| Cramps in legs | | | | Household contact with TB | | | |
| Depression or excessive worry | | | | Illegal substances use | | | |
| Dizziness or fainting spells | | | | Jaundice or hepatitis | | | |
| Easy fatigability | | | | Kidney stone/blood in urine | | | |
| Eating disorder | | | | Lack vision in either eye | | | |
| Epilepsy or seizure | | | | Liver problems | | | |
| Excessive bleeding | | | | Loss of finger or toe | | | |
| Eye surgery to correct vision | | | | Loss of memory or amnesia | | | |
| Foot trouble | | | | Motion sickness | | | |
| Frequent indigestion | | | | Nerve injury | | | |

Applicant Name (last, first) _____ Date of Birth _____

Physical Exam and Medical History (Continued)

CHECK EACH ITEM. IF "YES" add the age of occurrence/onset and explain **below**.

| | Yes | No | Age |
|------------------------------------|-----|----|-----|
| Nervous trouble of any sort | | | |
| Pain or pressure in chest | | | |
| Painful or trick shoulder or elbow | | | |
| Palpitation/ pounding heart | | | |
| Paralysis (including infantile) | | | |
| Parent/sibling sudden death | | | |
| Parent/sibling with cancer | | | |
| Parent/sibling with diabetes | | | |
| Parent/sibling with heart disease | | | |
| Parent/sibling with stroke | | | |
| Periods of unconsciousness | | | |
| Plate, pin or rod in any bone | | | |
| Recent gain/loss of weight | | | |
| Recurrent back pain or injury | | | |
| Recurrent ear infection | | | |
| Rheumatic fever | | | |
| Scarlet fever | | | |
| Severe tooth or gum trouble | | | |
| Sexually transmitted disease | | | |

| | Yes | No | Age |
|----------------------------------|-----|----|-----|
| Shortness of breath | | | |
| Sickle cell disease | | | |
| Sinusitis | | | |
| Skin disease | | | |
| Sleepwalking | | | |
| Stomach/intestinal problems | | | |
| Stutter or stammer | | | |
| Sugar or albumin in urine | | | |
| Suicide attempt or plans | | | |
| Swollen or painful joints | | | |
| Thyroid trouble or goiter | | | |
| Tobacco use | | | |
| Trick or lock knees | | | |
| Tuberculosis or Positive TB test | | | |
| Tumor, growth, cyst, cancer | | | |
| Wear a brace or back support | | | |
| Wear a hearing aid | | | |
| Wear corrective lens | | | |
| X-ray or other radiation therapy | | | |

| Vision Exam | | |
|--------------|------------------------------|-----------------------------|
| Right 20/___ | Left 20/___ | Pupils - Equal/Unequal |
| Corrected | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

| Females Only | | |
|-------------------------------|------------------------------|-----------------------------|
| Treated for a female disorder | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Change in menstrual pattern | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Date of last period | | |
| Date of last pap smear | | |

Physician Comments on All "Yes" Answered Questions in Physical - attach additional paper if necessary.

| | |
|--|--|
| Physician's Clearance for Participation in the Washington Youth Academy | |
| Student is cleared for participation with NO Restrictions | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If "NO" please explain | |
| | |
| | |

| | | |
|--------------------------|---|------|
| Physician's Signature | X | Date |
| Physician's Printed Name | X | / / |

REQUIRED Physician's Office Stamp:

Additional Comments:



Medical Application

Request for Special Dietary Accommodations Only Eligible with Doctor's Order



Are you requesting Special Dietary Accommodations while attending the Washington Youth Academy?

Yes **Complete the form. Doctor completes Diet Order.**

No **The form is now complete.**

| | |
|---|---|
| Applicant Name _____ | Date of Birth _____ |
| Parent/Guardian Name _____ | Phone number _____ |
| Mailing Address _____ | City/State/Zip _____ |
| <i>Washington Youth Academy</i> Program _____ | <i>Washington Youth Academy</i> Grade/Classroom _____ |
| Signature of Parent/Guardian _____ | Date _____ |

Diet Order

Federal Law and USDA regulation require nutrition programs to make reasonable modifications to accommodate children with disabilities. Under the law, a disability is an impairment which substantially limits a major life activity or bodily function, can include allergies and digestive conditions, but does not include personal diet preferences.

1. Describe how the impairment affects the child (i.e., how the ingestion/contact with the food impacts the child.)

2. Explain what must be done to accommodate the child's diet (i.e., specific food(s) to be omitted/avoided)

3. List food(s) and/or beverages to be substituted, provided or modified:

Required Authorization

| | | |
|---|-------------|--------------------|
| | | |
| Signature of State-Recognized Medical Authority* | Date | Clinic Name |

* State-Recognized Medical Authority is a licensed health care professional authorized to write medical prescriptions in Washington: Medical Doctor (MD), Doctor of Osteopathy (DO), Physician's Assistant (PA) with prescriptive authority, Naturopathic Physician, or Advanced Registered Nurse Practitioner (ARNP).



Medical Application

Over-the-Counter (OTC) Medications Authorization



The following list of medications will be used for health complaints while student is attending the WYA

| Health Complaint | Examples of Medications Used |
|--------------------------|--|
| Acne | 5% Benzoyl Peroxide Topical |
| Allergies | Allegra, Benadryl, Claritin, Zyrtec |
| Athlete's Foot | Lotrimin, Tinactin spray, Dr. Scholl's foot powder |
| Bee Sting | Benadryl cream, Calamine |
| Cold/cough/sore throat | Dayquil/Nyquil |
| Constipation | Benefiber, Miralax |
| Cramps | Pamprin (or equivalent) |
| Cuts/scrapes/lacerations | Betadine, bacitracin, triple antibiotic ointment (TAO) |
| Diarrhea | Pepto Bismol |
| Ear care | Debrox |
| Eye irritation | Saline eye wash |
| Ingrown toenail | Epsom salt soak, Betadine soak |
| Irritated skin/bug bites | Aloe, calamine, Benadryl cream/spray, hydrocortisone cream |
| Minor burns/sunburn | Aloe, sunscreen lotion/gel/spray |
| Pain/fever/headache | Tylenol, Ibuprofen, Aleve |
| Sore muscles | Ben Gay, Bio Freeze, Epsom salt |
| Sore rectum | Preparation H |
| Upset stomach/heartburn | TUMS, Prilosec, Pepto-Bismol (or equivalent) |

This is a standing order for individual Applicants only during the 22-week program.

To be considered for admission, ALL OTC medications and food supplements must be approved by doctor.

I authorize WYA medical staff to give **ALL** OTC medications (per label instructions) for the treatment of minor injuries and illnesses as listed above. Before giving any medications, the medical staff will check the medical history, allergies and any other medications that are taken to make sure there is no potential for interaction. I give the WYA medical staff permission to treat my patient's minor illnesses with the OTC meds listed above.

| | | |
|--------------------------|----------|------|
| Physician's Signature | X | Date |
| Physician's Printed Name | X | |

REQUIRED Physician's Office Stamp:

Additional Comments:



Medical Application

Medication at WYA Form

Physician/Parent/Applicant Authorization



I give permission to the medical staff to administer the medication(s) listed below and to communicate as warranted with the undersigned physician regarding my child's medication. I hereby agree to indemnify and hold forever harmless the WYA and their respective officials, agents, servants, and employees against loss from any and all claims, demands, or actions in law or in equity that may hereafter at any time be made or by said minor or by anyone on behalf of said minor for the purpose of enforcing a claim for damages on account of any injuries or loss sustained in consequence of the aforesaid assistance, and we do hereby waive any and all rights of exemption, both as to real and personal property, to which we may be entitled under the laws of this or any other state as against such claim for reimbursement or indemnity.

| | | |
|------------------------------|------------|------------|
| Parent/Guardian Printed Name | | |
| Parent/Guardian Address | | |
| Work Phone | Cell Phone | Home Phone |
| | | |

| | |
|---------------------------------|------|
| Applicant Signature | Date |
| Parent/Legal Guardian Signature | Date |

Physician's Orders

(To be completed by Licensed Health Professional)

Please list all prescription medication. All medications to be given by Nebulizer must be provided in individual unit doses. Inhalers: The physician must sign consent to carry inhaler on person.

| Medical Condition | Medication Name | Strength | Dosage | Route | Physician Signature |
|-------------------|-----------------|----------|--------|-------|---------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |



Medical Application

Immunization Instructions

Immunizations **MUST BE** reported on the WYA form only.



All applicants are required to report immunization they have received. This is reported on the **Certificate of Immunization Status Form (CIS)** on the next page. Please follow the instructions below to ensure this is accepted by the Admission staff.

Checklist

- Box #1 - Print the Applicant name, birthdate and gender.
- Box #2 - Print the Applicant's parent/guardian name.
- Box #3 - Parent/guardian signs and dates.
- Box #4 - If the Applicant has had chickenpox, note the disease history.
- Box #5 Using the Applicant's immunization record, copy each immunization in the appropriate box on the form. Each line should have the vaccine name and the date given. (See example below.)

| Vaccine | Dose | Date | | |
|-----------------------|------|-------|-----|------|
| | | Month | Day | Year |
| ◆ Hepatitis B (Hep B) | | | | |
| Hep B | 1 | 3 | 27 | 1999 |
| Hep B | 2 | 6 | 4 | 1999 |
| Hep B | 3 | 9 | 28 | 2000 |

Applicants must meet the Required Vaccinations in order for their application to be considered.

Required Vaccinations

Diphtheria, Tetanus, Pertussis (DTaP)

5 doses with the last dose after 4th birthday.
4 doses are acceptable if the last dose is AFTER the 4th birthday.

Tetanus , Diphtheria, Pertussis (Tdap)

1 dose required for all Applicants.

Hepatitis B (Hep B)

3 doses required for all Applicants.

Polio (IPV, OPV)

4 doses with the last dose before 4th birthday.

Measles, Mumps, & Rubella (MMR)

1st dose after 1st birthday.
2nd dose AFTER 13th month of age.

Varicella (chickenpox)

2 doses required for all Applicants.

Applicant Name (last, first) _____ Date of Birth _____



Certificate of Immunization Status (CIS)

DOH 348-013 January 2015

Office Use Only:
 Reviewed by: _____ Date: _____
 Signed Cert. of Exemption on file? Yes No

Please print. See back for instructions on how to fill out this form or get it printed from the Immunization Information System.



Child's Last Name: _____ **First Name:** _____ **Middle Initial:** _____ **Birthdate (mm/dd/yyyy):** _____ **Sex:** _____

I give permission to my child's school to share immunization information with the Immunization Information System to help the school maintain my child's school record.

Parent/Guardian Signature Required _____ Date _____



Symbols below:
 ◆ Required for School and Child Care/Preschool
 ● Required for Child Care/Preschool Only
 ■ Recommended, but not required

I certify that the information provided on this form is correct and verifiable.



| Vaccine | Dose | Date | | |
|---|------|-------|-----|------|
| | | Month | Day | Year |
| ◆ Hepatitis B (Hep B) | | | | |
| | 1 | | | |
| | 2 | | | |
| | 3 | | | |
| or Hep B - 2 dose alternate schedule for teens | | | | |
| | 1 | | | |
| | 2 | | | |
| ■ Rotavirus (RV1, RV5) | | | | |
| | 1 | | | |
| | 2 | | | |
| | 3 | | | |
| ◆ Diphtheria, Tetanus, Pertussis (DTaP, DTP, DT) | | | | |
| | 1 | | | |
| | 2 | | | |
| | 3 | | | |
| | 4 | | | |
| | 5 | | | |
| ◆ Tetanus, Diphtheria, Pertussis (Tdap) | | | | |
| | 1 | | | |
| ■ Tetanus, Diphtheria (Td) | | | | |
| | 1 | | | |
| | 2 | | | |
| ● Haemophilus influenzae type b (Hib) | | | | |
| | 1 | | | |
| | 2 | | | |
| | 3 | | | |
| | 4 | | | |
| ■ Influenza (flu, most recent) | | | | |



| Vaccine | Dose | Date | | |
|---|------|-------|-----|------|
| | | Month | Day | Year |
| ● Pneumococcal (PCV, PPSV) | | | | |
| | 1 | | | |
| | 2 | | | |
| | 3 | | | |
| | 4 | | | |
| | 5 | | | |
| ◆ Polio (IPV, OPV) | | | | |
| | 1 | | | |
| | 2 | | | |
| | 3 | | | |
| | 4 | | | |
| ◆ Measles, Mumps, Rubella (MMR) | | | | |
| | 1 | | | |
| | 2 | | | |
| ◆ Varicella (chickenpox) | | | | |
| | 1 | | | |
| | 2 | | | |
| ■ Hepatitis A (Hep A) | | | | |
| | 1 | | | |
| | 2 | | | |
| ■ Human Papillomavirus (HPV) – does not print from the IIS; write dates in by hand | | | | |
| | 1 | | | |
| | 2 | | | |
| | 3 | | | |
| ■ Meningococcal (MCV, MPSV) | | | | |
| | 1 | | | |
| | 2 | | | |

If the child named on this CIS had chickenpox disease (and not the vaccine), disease history must be verified.
 Mark option 1, 2, OR 3 below (see # 5 on back)

1) Chickenpox disease verified by printout from the Immunization Information System (IIS)
 Must be marked by printout (not by hand) to be valid.

2) Chickenpox disease verified by healthcare provider (HCP)
 If you choose this box, mark 2A OR 2B below.
 2A) Signed note from HCP attached OR
 2B) HCP sign here and print name below:

 Date _____

Licensed healthcare provider signature _____ Date _____
 (MD, DO, ND, PA, ARNP)

Printed Name: _____

3) Chickenpox disease verified by school staff from the Immunization Information System



If the child can show immunity by blood test (titer) and hasn't had the vaccine, ask your HCP to fill in this box.

Documentation of Disease Immunity

I certify that the child named on this CIS has laboratory evidence of immunity (titer) to the diseases marked.
Signed lab report(s) MUST also be attached.

Diphtheria Mumps Other: _____
 Hepatitis A Polio _____
 Hepatitis B Rubella _____
 Hib Tetanus _____
 Measles Varicella _____

 Date _____

Licensed healthcare provider signature _____ Date _____
 (MD, DO, ND, PA, ARNP)

Printed Name: _____

Student's Name (last, first) _____

Date of Birth _____



Medical Application

Behavioral Health Requirement



If you have ever received behavioral health services or have been hospitalized for behavioral health reasons, you will need to provide additional information with your application.

Below is a questionnaire to assist you in determining if this is necessary.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|-----------------------------|------------------------------|-----------------------------|---------|------------------------------|-----------------------------|------------------|------------------------------|-----------------------------|------------------|------------------------------|-----------------------------|------------|------------------------------|-----------------------------|-----------------------|------------------------------|-----------------------------|-------------------------------|------------------------------|-----------------------------|---------------|------------------------------|-----------------------------|--------------------------------|------------------------------|-----------------------------|---------------|------------------------------|-----------------------------|-------------------|------------------------------|-----------------------------|--------------|------------------------------|-----------------------------|
| 1. Have you been diagnosed and/or treated by a Therapist/Psychiatrist in the last 5 years for: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">Anger management</td> <td style="padding: 2px;">Yes <input type="checkbox"/></td> <td style="padding: 2px;">No <input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">Anxiety</td> <td style="padding: 2px;">Yes <input type="checkbox"/></td> <td style="padding: 2px;">No <input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">Bipolar disorder</td> <td style="padding: 2px;">Yes <input type="checkbox"/></td> <td style="padding: 2px;">No <input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">Conduct disorder</td> <td style="padding: 2px;">Yes <input type="checkbox"/></td> <td style="padding: 2px;">No <input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">Depression</td> <td style="padding: 2px;">Yes <input type="checkbox"/></td> <td style="padding: 2px;">No <input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">Dissociative disorder</td> <td style="padding: 2px;">Yes <input type="checkbox"/></td> <td style="padding: 2px;">No <input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">Oppositional defiant disorder</td> <td style="padding: 2px;">Yes <input type="checkbox"/></td> <td style="padding: 2px;">No <input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">Panic attacks</td> <td style="padding: 2px;">Yes <input type="checkbox"/></td> <td style="padding: 2px;">No <input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">Post traumatic stress disorder</td> <td style="padding: 2px;">Yes <input type="checkbox"/></td> <td style="padding: 2px;">No <input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">Schizophrenia</td> <td style="padding: 2px;">Yes <input type="checkbox"/></td> <td style="padding: 2px;">No <input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">Violent outbursts</td> <td style="padding: 2px;">Yes <input type="checkbox"/></td> <td style="padding: 2px;">No <input type="checkbox"/></td> </tr> <tr> <td style="padding: 2px;">Other: _____</td> <td style="padding: 2px;">Yes <input type="checkbox"/></td> <td style="padding: 2px;">No <input type="checkbox"/></td> </tr> </table> | Anger management | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Anxiety | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Bipolar disorder | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Conduct disorder | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Depression | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Dissociative disorder | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Oppositional defiant disorder | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Panic attacks | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Post traumatic stress disorder | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Schizophrenia | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Violent outbursts | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Other: _____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Anger management | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Anxiety | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Bipolar disorder | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conduct disorder | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Depression | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Dissociative disorder | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Oppositional defiant disorder | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Panic attacks | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Post traumatic stress disorder | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Schizophrenia | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Violent outbursts | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other: _____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. Have you ever been hospitalized for a suicide attempt? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. Have you ever been prescribed medication for behavioral health reasons, regardless of whether you took it or not? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

If you answered "Yes" to any of these questions, you will need to obtain a letter from a Behavioral Health Provider. Please refer to page **Medical-10** for instructions.

| | |
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| By signing below, you ensure to the best of your knowledge, all information provided is true and accurate. | |
| Applicant Signature | Date |
| Parent/Legal Guardian Signature | Date |



Medical Application Behavioral Health Letter



Applicant - Please present this letter to your Behavioral Health Provider for assistance securing the documents needed to be considered for the WYA.

Dear Provider,

The client presenting this letter is applying to the Washington Youth Academy. The WYA is a 5½ month residential program with a quasi-military structure, strict adherence to discipline, rules, order and encompasses a high-stress environment. The Cadets live in an open-bay dorms with 55 others and attend school daily. Cadets wake at 5 a.m. followed directly by physical training, complete 40 hours of service to community and, if successful, earn 8 high school credits. If you would like more information about the WYA, please visit our website (see below).

Please provide the client with a letter addressing the following:

- Client's current diagnosis and former diagnosis if applicable.
- Treatment plan for client to include: frequency of sessions, goals, client's progress, coping/strategies, stress reduction plan, identified triggers etc.
- Any corresponding psychiatric services to include: current medications and dosage, history of medication management/client's responsiveness to the medication, etc.
- Treating Therapist/Psychiatrist's professional opinion on the mental/emotional stability of the client and their ability to complete this program.

*Note: WYA is not equipped to provide on-going behavioral health counseling services. However, brief intervention and guidance counseling services are provided.

Please contact us if you have questions.

| |
|--|
| WA Counties North of I-90 and Kitsap, Mason Counties |
| Contact Admission Specialist |
| Elizabeth "Liz" Bergmann |
| Phone: (360) 473-2615 |
| elizabeth.bergmann@mil.wa.gov |

| |
|---|
| WA Counties South of I-90 Jefferson, Clallam, Grays Harbor Thurston and Pierce Counties |
| Contact Admission Specialist |
| Kelly Ingalls |
| Phone: (360) 473-2617 |
| kelly.ingalls@mil.wa.gov |

Washington Youth Academy
Admissions Department
1207 Carver Street
Bremerton, WA 98312
Toll Free (877) 228-8947 FAX (360) 473-2623
<http://mil.wa.gov/youth-academy>



Medical Application

Understanding of Limited Medical Services

Page 1 of 2



Applicant LEGAL NAME

DATE OF BIRTH

| | | |
|-------|--------|-----|
| Last: | First: | / / |
|-------|--------|-----|

Overview:

The Washington Youth Academy is NOT a hospital, medical, dental or mental health clinic. We have a licensed nurse on staff. For this reason, we are unable to accept applications from Applicants who require ongoing medical or dental care for conditions that originated prior to arrival at the program or that develop after enrollment that prevents their full participation on a daily basis. Minor illnesses and injuries that arise during the program are handled on a “sick call” basis. Cadets with more serious illnesses or injuries will be taken to a local clinic or hospital emergency room as appropriate. Please note, if the illness or injury is serious, it could jeopardize the Cadet’s continued enrollment. The WYA does not have staff available to transport Cadets to frequent medical, dental or vision appointments or provide ongoing treatment or care. Cadets with medical issues that will impact their daily participation will be dismissed and sent home. The Cadets can reapply to a future class and compete for admission as long as they are in good standing in all other areas. Any periodic appointments for preventative medical, dental or vision care must be made when the Cadet is at home during a scheduled break or “home pass”. Appointments scheduled while on home pass should not overlap with the Cadet’s scheduled time for return, as this will put the Cadet at risk of not completing the required training and attendance for successful completion. These policies and procedures are intended and designed to ensure the safety, health and welfare of the Cadets and staff of the WYA.

IT IS IMPERATIVE APPLICANTS ARE FORTHCOMING AND HONEST ABOUT ALL MEDICAL AND MENTAL HEALTH QUESTIONS. THE FOLLOWING CONDITIONS, WHETHER DISCLOSED OR NOT MAY PREVENT ENROLLMENT.

- Extensive use of multiple medications necessary to treat multiple conditions on a daily basis.
- Extensive dietary restrictions medically required by a physician.
- Previous or current injuries/surgeries that prevent daily participation in all physical and mental activities.
- Dental conditions or appliances that will require near-term or ongoing treatment or that will impact the Cadet's ability to participate in daily activities.
- Conditions or medications that adversely react to or have side effects impacted by rigorous physical activity or seasonal weather conditions that may compromise the health, safety or welfare of the Cadet or his/her fellow Cadets and staff.
- Historic or current conditions requiring medical, psychological or psychotic intervention for suicide prevention, manic depression, anxiety, etc. The WYA does not provide mental health care services.

IMPORTANT NOTE: Participants must provide full and accurate information concerning any and all medical and psychological conditions—as outlined above—at the time of application and report any and all changes to said conditions prior to the beginning of the program.

A complete physical exam by a licensed medical examiner must be completed no more than 1 year from the start of the program. After the start of the program, if an undisclosed condition is identified, the Cadet will be dismissed from the program and returned home. The WYA cannot and will not assume any financial or personal liability or risk for participants that have previous medical, physical or mental health conditions or disorders that could or would be impacted by the rigorous nature of the program.

Applicant Name (last, first) _____ Date of Birth _____



Medical Application

Understanding of Limited Medical Service

Page 2 of 2



Policies Governing Medications and Medical Care

- All required prescription and non-prescription medications must be disclosed in advance during the application process.
- All potential side effects and limitations of required medications must be disclosed at time of application.
- A medical release and approval to participate must be signed by a doctor and received by the Admissions Office before final acceptance can be issued.
- Parents/legal guardians are entirely responsible for all medical costs, including prescription medications and refills, that may be incurred by the Cadet while attending the WYA.
- Parents/legal guardians are responsible for all medical, dental, vision and psychological care before, during and after attending the WYA.

Medical Insurance Policy

→ **Initial** _____ I understand that the WYA, Washington Military Department (WMD) and the State of Washington are NOT providing any medical insurance coverage for my child to attend the WYA. Medical services provided by a billing medical or emergency service will not be paid by the WYA, WMD or the State of Washington.

→ **Initial** _____ I understand and agree I am financially responsible for all medical services provided by a billing medical or emergency service provider which may include: medical services, medical testing, treatment/care, prescriptions, surgery, ambulance services or any form of emergency services.

→ **Initial** _____ If insurance coverage is provided, I accept responsibility for billing for deductible amounts, co-insurance, non-covered services or services not paid as determined by the insurance carrier. I understand if there is no insurance or the insurance terminates (coverage no longer exists), I agree to pay for all bills associated to medical or emergency services. The provider's billing for uninsured services I would be responsible to pay may include additional fees such as finance charges or other service-related charges.

| | |
|--|--|
| Primary Parent/Guardian Date of Birth | |
| Primary Parent/Guardian's Employer | Unemployed/Retired <input type="checkbox"/> |

Acknowledgement of Understanding

I understand and agree to be responsible for all medical, dental and mental health care of my youth during, before and after participation in the WYA. In the event that I cannot be contacted through reasonable efforts, I hereby empower and grant WYA staff permission to provide medical care and/or transport my child to a local medical clinic, urgent care center and/or medical institution for further medical evaluation. I understand, should my child need more invasive diagnostic or surgical procedures, attempts will be made to contact me before such are initiated. I further understand, once my child reaches the age of majority, my consent for treatment is no longer required. I understand that I am entirely responsible for all medical costs including prescription medication. By signing this, I acknowledge that I have read and understand this consent.

| | |
|--|------|
| By signing below, you ensure to the best of your knowledge, all information provided is true and accurate. | |
| Applicant Signature | Date |
| Parent/Legal Guardian Signature | Date |



Medical Application

Authorization to Release Medical Information



Applicant LEGAL NAME

DATE OF BIRTH

| | | | |
|-------|--------|---|---|
| Last: | First: | / | / |
|-------|--------|---|---|

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the released information may be subject to re-disclosure by the recipients only as required to process a claim for benefits and no longer be protected by federal privacy regulations.

Medical Provider

The Washington Youth Academy, located at 1207 Carver St., Bremerton is a division of the Washington Military Department (WMD) and is authorized to receive and use the information in connection with my medical history, treatment and physical or mental health examination. I further authorize that a photocopy of this medical release may be used by the Washington Youth Academy to request and obtain medical information.

Specific description of information: complete medical record for all dates of service and all admissions including, but not limited to history and physical exam; progress notes; office notes and letters; office chart; laboratory reports; diagnostic test reports including, but not limited to MRI, CT scan, bone scan, x-ray reports or films, inpatient admissions and discharge reports; and physical therapy. This information may include medical services including: **psychiatric care, alcohol and drug rehabilitation** and communicable diseases that may also affect my attendance in an intense residential program.

The purpose of use or disclosure of patient information is for my application and attendance in a residential education program. Patient information may be used or disclosed to determine, administer and/or coordinate a treatment plan and/or litigate a claim. Patient information may be re-disclosed to the parties, their agents and representatives; to the WYA and the WMD independent medical examiners and/or care providers contracted by the WYA patient's private insurance or health program coverage provided by the State of WA Washington entities involved in any third party action arising out of providing medical care, the Attorney General's Office, county and/or district courts, and any of my past or present health care providers.

I also understand that I may revoke this consent at any time except to the extent that action has been taken. This consent automatically expires thirty-six (36) months from the date my application is accepted and I am officially registered as a Cadet in the WYA.

- **I understand** that I am entitled to receive a copy of this authorization.
- **I understand** that I may revoke this authorization at anytime by notifying the providing organization in writing; however, such revocation will not affect any actions the provider took before it received the revocation. Any use or disclosure made prior to the revocation of this authorization will not be affected by a revocation.
- **I understand** that I may refuse to sign this form; however, the lack of appropriate medical information may affect the processing of my application or attendance in the program.

| | |
|--|------|
| By signing below, you ensure to the best of your knowledge, all information provided is true and accurate. | |
| Applicant Signature | Date |
| Parent/Legal Guardian Signature | Date |

Application Information Statement

By signing below, I confirm that I have been accurate and complete in all the information I have provided to the WYA through the Application Process

Student Signature

Date

Parent/Legal Guardian Signature

Date

Authorization to Release Confidential Information

Purpose: In processing your application, there may be a need to confirm or clarify personal information you've provided with an outside agency. This form authorizes us to contact those agencies and exchange information.

Student Name:

Date of Birth:

County where student currently lives:

Other Washington counties where student has lived:

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the State of Washington, its counties, its cities, and its agencies including school districts and treatment program facilities, to submit and/or exchange all pertinent information with the Washington Youth Academy (WYA) regarding, but not limited to the following: substance abuse history, referral history, court status, family or social services interventions, documented medical conditions, and any other information requested by the WYA relevant to the health, safety, welfare, and quality of life of the student named above.

I understand that these records are protected under the federal or state confidentiality laws or regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. WYA is in compliance with the most prominent of the federal protections for participant privacy including the Family Educational Rights and Privacy Act (FERPA). Also known as the "Buckley Amendment" FERPA protects the confidentiality of student records to some extent, while giving students the right to review their own records.

I also understand that I may revoke this consent at any time except to the extent that action has been taken. This consent automatically expires thirty-six (36) months from the date my application is accepted and I am officially registered as a student in the WYA.

By signing below, you ensure to the best of your knowledge, all information provided is true and accurate.

Student Signature

Date

Parent/Legal Guardian Signature

Date

