Documents Needed to Complete Your Application

Your application is not complete until all the documents have been received.

Medical Documents - Forms 1-7. To Be Printed. These documents require signatures from you, your parent/guardian, doctor, and dentist. *Please note. Immunization record from your doctor is required. Please request a copy during your physical.

- Sports Physical – Forms 1-5. These pages go to your doctor.
- Dental exam – Form 6. This page goes to your dentist.
- Medical Release – Form 7. This is signed by you and your parent/guardian.

Required Identification Documents, School Documents and Medical Cards. (Copies only)

- **US Birth Certificate**; **Permanent Resident Card (I-551) or Certificate of Citizenship**
- **Social Security Card or Social Security Number**
- **Picture Identification Card** – School ID card, Tribal ID card, WA ID card or US Passport.
- **High School Transcript** (unofficial)
- **High School Graduation Requirement Checklist** from your school counselor.
- **Special Education** Documents (if applicable)
  - IEP with 3 yr. Evaluation or 504 Accommodation Plan.
- **Medical Insurance cards,** front and back of cards.
- **Copy of Immunization record from doctor.** Applicants must to have all the immunizations required to attend a Washington State public school. Request the immunization form from your doctor.

Submission of Documents

Submission by Email – If you want to submit these documents by email, please scan into one pdf document and attach to the following email address. **wya.applications@mil.wa.gov**

Submission by FAX – If you want to submit these documents by fax, please send and then verify that we have received these by phone or by sending us an email. FAX (360) 473-2623

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

Form 1 -- WYCA Sports Physical

MUST BE WITHIN 1 YEAR OF ENTRY

Medical Provider – Please Note

The WYCA is a 5½ month residential program that conducts rigorous physical training daily. Our physical training program is taken directly from the U.S. 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 functional fitness.

Applicant Name_____ Date of Birth_____

Date of Exam_____ Height_____ Weight_____ Present Health (circle) Good Average Poor

WYCA Physical Exam and Medical History – check each item.

If yes, add the age of occurrence/onset and explain on the next page.

	Yes	No	Age
Adverse reaction to medicine			
Alcohol use			
Arthritis, rheumatism or bursitis			
Asthma			
Back pain or back injury (recurrent)			
Back support or back brace			
Bacterial/viral infection			
Bed wetting since age 12			
Blood in sputum			
Bone, joint or other deformity			
Broken bones			
Chemotherapy/Radiation			
Chronic coughing			
Chronic or frequent colds			
Corrective lens or glasses			
Cramps in legs			
Depression			
Diabetic (type I or II)			
Dizziness or fainting spells			
Easy fatigability			
Eating disorder			
Epilepsy/seizure/cerebral palsy			
Excessive bleeding			

	Yes	No	Age
Eye surgery to correct vision			
Foot trouble			
Frequent indigestion/GERD			
Frequent or severe headaches			
Frequent trouble sleeping			
Frequent/painful urination			
Gall bladder problems			
Hay fever or allergic rhinitis			
Head injury			
Head Lice			
Hearing aid			
Hearing loss			
Heart trouble or murmur			
Hemorrhoids/rectal disease			
Hepatitis or Jaundice			
Hernia			
High or low blood pressure			
Household contact with TB			
Illegal substances use			
Kidney stone/blood in urine			
Knee injury or knee surgery (describe)			
Lack vision in either eye			
Liver problems			

Form 2 – WYCA Sports Physical

Applicant Name_____ **Date of Birth** _____

	Yes	No	Age
Loss of finger or toe			
Loss of memory or amnesia			
Menstrual patterns changes			
Motion sickness			
Nerve injury			
Nervous, excess worry, anxiety			
Pain-chest or pressure in chest			
Pain-joint or swelling joint			
Pain-knee			
Pain-shoulder or elbow			
Palpitations in 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 body			
Recurrent ear infection			
Reproductive organ pain or disorder			

	Yes	No	Age
Rheumatic fever history			
Scarlet fever history			
Severe tooth or gum trouble			
Sexually transmitted disease (current)			
Surgery within the last year			
Shortness of breath			
Sickle cell disease			
Sinusitis			
Skin-eczema, psoriasis, growths			
Sleepwalking			
Stomach/intestinal problems			
Stutter or stammer			
Suicide attempt(s)			
Suicide ideations(s)			
Swollen or painful joints			
Thyroid trouble or goiter			
Tobacco use			
Tuberculosis or Positive TB test			
Tumor, growth, cyst, cancer			
Weight gain in last year			
Weight loss in last year			

Required Vision Screening

Right 20/____Left 20/____ Pupils (circle) Equal Unequal

Corrected (circle) Yes No

Provider – If vision exam determines greater than 20/30 vision, please refer to optometrist.

Provider comments on all yes answered questions in the physical.

_____

_____

Any other medical issue(s) to disclose, not already on this form.

_____

_____

By signing, I have determined this youth has no physical restrictions for participation.

Provider's Office Info or Stamp

Provider Signature _____ **Date**_____

Provider Printed Name _____

If youth is not fully cleared for participation, please explain:

_____

_____

_____

Form 3 -- WYCA Request for Special Diet Accommodations

Only Eligible with Provider's Order

Applicant Name_____ Date of Birth_____

Completed by All Applicants and Parent/Guardian

Are you requesting Special Dietary Accommodations while attending the WYCA?

Circle One: Yes or No

Applicant Signature _____ Date_____

Parent Signature_____ Date_____

Diet Order – Completed by the Provider ONLY

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.

Food Allergies	Reactions

Religious Food Accommodations

_____

_____

_____

List food(s) and/or beverages to be substituted, provided, or modified for food allergy or religious accommodation.

_____

_____

_____

Other:

_____

Provider's Signature _____ **Date**_____

Provider's Printed Name _____

Provider's Office Info or Stamp

Form 4 --WYCA Medication Authorization OTC

Applicant Name_____Date of Birth _____

The following list of medications may be used for health concerns while attending the WYCA, under the care of the Registered Nurse.

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

To be considered for admission, ALL OTC medications or equivalents below must be approved by the provider.

Health Complaint	Examples of Medications Used
Acne	Benzoyl Peroxide Topical
Allergies	Loratadine, cetirizine, fexofenadine, diphenhydramine (acute use only)
Athlete's Foot	Clotrimazole, tolnaftate, medicated foot powder
Bee Sting	Diphenhydramine topical, Calamine lotion, Sting relief wipes
Cold/cough/sore throat	Cold/Flu medicine, sugar free cough drops
Constipation	Wheat fiber/dextrin, polyethylene glycol, Magnesium citrate
Cramps (menstrual)	Menstrual cramp relief
Cuts/scrapes/lacerations	Betadine, bacitracin, triple antibiotic ointment
Diarrhea	Bismuth salicylate, antacid (oral)
Ear care	Debrox, hydrogen peroxide
Eye irritation	Saline eye wash
Ingrown toenail	Epsom salt soak
Irritated skin/bug bites	Aloe vera, calamine lotion, hydrocortisone topical
Irritated skin/bug bites (continued)	diphenhydramine topical, Colloidal Oatmeal 1% topical
Minor burns/sunburn	Aloe vera, first aid/burn cream/lotion
Pain/fever/headache	acetaminophen, Ibuprofen, naproxen, Orajel (tooth use only)
Skin cleansers	Chlorhexidine, povidone/betadine
Skin protectant	lip balm white petroleum/medicated, sunscreen, A & D ointment
Sore muscles	Bio Freeze
Sore rectum	Phenylephrine topical
Upset stomach/heartburn	Antacid, omeprazole, famotidine

I authorize WYCA 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 medication that are taken to make sure there is no potential for interaction. I give the WYCA medical staff permission to treat my patient's minor illnesses with OTC meds listed above.

Provider's Office Info or Stamp

Provider's Signature _____ **Date**_____

Provider's Printed Name _____

Form 5 -- WYCA Prescription Medication

Applicant Name_____ Date of Birth _____

Completed by All Applicants and Parent/Guardian

I give my permission to the medical staff to administer the medications(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 WYCA and their respective officials, agents, servants and employees against loss form 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 a foresaid 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.

Applicant Signature _____ Date_____

Parent Signature_____ Date_____

Completed by Provider - Allergies

Allergies-Anaphylactic /Reactions

_____

_____

Allergies-Medications, Insects, Seasonal

_____

_____

Allergies-Non-Anaphylactic Food Allergies/Intolerances

_____

_____

Completed by Provider – Medications - Provider's Orders

Please list all prescription medication. All medications to be given by Nebulizer must be provided in individual unit doses.
Rescue Inhalers-by signing physicians authorize consent to carry rescue albuterol inhaler on person.

MEDICAL CONDITION	MEDICATION NAME	STRENGTH	DOSAGE	FREQUENCY	ROUTE	**Provider's SIGNATURE**

Form 6 -- WYCA Dental Exam

MUST BE WITHIN 1 YEAR OF ENTRY

Applicant Name: _____Date of Birth_____

Dental Exam Date: _____

COMPLETE	**By selecting one of the two circles to the left, the applicant can proceed in the admission process. Any dental work should be complete by the applicant but is not required for admission.**
◯	Youth has good oral health and is not expected to require dental treatment or reevaluation for 12 months.
◯	Youth has some oral conditions, but you **DO NOT** expect these conditions to result in dental emergencies within 12 months if not treated (i.e., requires prophylaxis, asymptomatic caries with minimal extension into dentin, edentulous areas not requiring immediate prosthetic treatment.)

INCOMPLETE	**By selecting the circle to the left and one of the four circles below, the applicant cannot proceed with admission to the program unless dental work is completed by July 1, 2025.**
◯ **Appointments must be made and listed below.**	Youth has oral conditions that you **DO** expect to result in dental emergencies with twelve (12) months if not treated. Examples of such conditions are: (X the applicable block or specify in the space provided)

◯	**Infections**: Acute oral infections, pulpal or periapical pathology, chronic oral infections, or other pathologic lesions and lesions requiring biopsy or awaiting biopsy report.
◯	**Caries/Restorations:** Dental caries or fractures with moderate or advanced extension into dentin; defective restorations or temporary restorations that patients cannot maintain for twelve (12) months.
◯	**Periodontal Conditions:** Acute gingivitis or pericoronitis, active moderate to advanced periodontitis, periodontal abscess, progressive mucogingival condition, moderate to heavy subgingival calculus or periodontal manifestations of systemic disease or hormonal disturbances.
◯	**Oral Surgery**: Unerupted, partially erupted, or malposed teeth with historical, clinical, or radiographic signs or symptoms of pathosis that are recommended for removal.
◯	**Other:** Temporomandibular disorders or myofascial pain dysfunction requiring active treatment.

◯	Youth with dental appliances. **Adjustments cannot be made during the 5.5-month residential program from 7/14-12/12.** **Can this youth participate without adjustments? YES or NO (circle one)**

All dental work required for admissions must be completed by January 1st. Please list dental appointments below. Documentation from the dental office is required after the completion of the dental work.

_____

_____

Any other dental issues to disclose, not already on this form:

_____

_____

Dentist Signature _____ **Date**_____

Dentist Printed Name _____

Dentist Office Info or Stamp

Form 7 -- WYCA Authorization to Release Medical Information

Applicant Name_____ **Date of Birth**_____

Medical/Dental Provider

The Washington Youth ChalleNGe Academy Health Center 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 ChalleNGe 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 charts; 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 WYCA and the WMD independent medical examiners and/or care providers contracted by the WYCA 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 WYCA.

- **I understand** that I am entitled to receive a copy of this authorization.
- **I understand** that I may revoke this authorization at any time 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.

I hereby authorize the use and/or disclosure of my individually identifiable health information as described above. 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.

Completed by All Applicants and Parent/Guardian

Applicant Signature _____ **Date**_____

Parent Signature_____ **Date**_____