



PRINT THIS ATTACHMENT



Additional Required Documents

Your application will not be considered until all the documents have been received.

Identification and School Documents

- Proof of Legal Residency: 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

WYCA Medical Forms-Medical Insurance Cards-Immunizations.

- **Sports Physical Form 1-3.** These pages require health care provider's exam and signatures. Only physicals on the WYCA forms are accepted. Vision Screening – If you do not pass the 20/30 vision screening, you are required to get a vision exam by an optometrist. A copy of the exam must be submitted to satisfy this requirement.
- **Medical Form 4 – Special Diet.** A health care provider's signature is required for a Special Diet. **Parent/Guardian and Applicant must sign this form.**
- **Medical Form 5 – Medications.** A health care provider's signature is required for prescription medications. **Parent/Guardian and Applicant must sign this form.**
- **Medical Form 6 – Release.** **Parent/Guardian and Applicant must sign this form.**
- **Dental Exam Form 7 –** This page requires dentist's signature. The Applicant must be cleared by the dentist to participate in the WYCA program.
- **Medical Insurance cards.** Please send a picture of the front and back of the cards. If you do not have the cards, order them now or ask if copies can be downloaded. If you have state insurance, you can download an electronic copy of your card by using the Health Care Authority App found at this link [Replace my services card | Washington State Health Care Authority](#)
- **Immunization Record.** This can be obtained from your doctor or you can access your immunization information through the Department of Health website. Register and download it here. [MyIRMobile - MyIR Mobile](#)

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

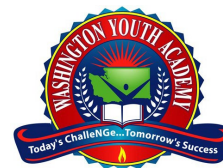
Submission by FAX – If you want to submit these documents by fax, please send and then verify that we have received these by phone or by sending us an email. FAX (360) 473-2623

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 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 applicants 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 Signature _____ **Date** _____

Provider's Printed Name _____

Provider's Office Info or Stamp



Form 4 -- 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 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 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.

Applicant Signature _____ Date _____

Parent Signature _____ Date _____

Completed by Provider – Allergies

Allergy	Reaction	Anaphylactic – Yes or No
		Yes / No
		Yes / No
		Yes / No
		Yes / No

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 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 _____

