Subject: Medical Requirements for Enrollment

Project Challenge wants to provide the BEST care possible for your child. In order to do this we need a few things from YOU. Please take a moment and review this important information.

- **SPORTS PHYSICAL EXAM** (Current – less than one year old) – We have a rigorous physical fitness program and childs need to have a Doctor's clearance prior to participation. If there are any Medical Restrictions we need to know about them. Your child must also be tested for all **SEXUALLY TRANSMITTED DISEASES (STD) and LICE** (This is part of the **"Physical Evaluation form".** Have the doctor note it on this form).
- **EYEGLASSES (Current Prescription) –** If your child wears glasses, please make sure **they bring (2 pair) them on enrollment day**, so they are able to participate in their daily classes. Prescriptions should be **less than one year** old upon enrollment.**(Contact lenses are not allowed under ANY circumstances)**
- **FEMALES**- Females need to visit a gynecologist prior to June 15, 2007 for the following: A "Well-Woman" exam. Any child taking the Depo-Provera Inj. Needs to change to the pill form of BCP during the program. Results need to be submitted to us prior to June 15, 2007.
- **MEDICAL / PSYCHOLOGICAL TREATMENT** - If your child is being treated for a Physical or Psychological condition, and is on prescribed medications, we need the current history and medical release from the treating doctor stating your child is able to participate in the program. If your child recently came off medications we need to know. All of the above needs to be submitted to us prior to intake day.
- **IMMUNIZATIONS (SHOTS) (Current) –** Children must have up-to-date shots prior to intake day. By law, a child cannot attend if his or her record does not show the month and year (month, day, and year for MMR) of each required dose. Children without a complete immunization record or with an inadequate record must be referred to a physician or health department for immunization before entry. Inadequately immunized children must have at least one current dose of each vaccine to attend.
- **MEDICAL POWER OF ATTORNEY -** This is a two page front and back form. BE sure to read and INITIAL every paragraph, and then have it **NOTARIZED** on the last page. **ALL BLANKS MUST BE FILLED.**
- **PRIMARY CARE PHYSICIAN** – If your child's primary care physician is not located within 20 miles of Project Challenge, contact your insurance company **NOW** and request a primary care physician in the following East Valley Zip Codes: **85204, 85205, 85206, 85242.** Cadets who do not have a primary care physician assigned to them in the East Mesa area will be taken to **CHW QC Medical Center** or **Gilbert Hospital** for treatment. All medical fees will be the responsibility of the parent or guardian.
- **MEDICAL CARE COSTS** – **Parents/Guardians are responsible for all medical bills not covered by your Insurance.** Having insurance will not only help us, but will also help you and your child.
- **PRESCRIPTIONS** – If your child takes medications, be sure to bring them in the **original** pharmacy bottle with your childs name on it. This includes birth control pills. If possible, have your Doctor write a prescription with enough re-fills for the entire 5 months. All prescriptions should be called in to: **Safeway Pharmacy (480) 279-0521 (Power Rd. and Queen Creek Rd.)**
- **PRESCRIPTION RENEWALS** – It is **your responsibility** to get renewals of the medications and make sure that Safeway Pharmacy receives the prescription. We do not want your child to miss any medications. We will pick up the prescriptions during class session and provide access to them as directed by the Doctor.
- **DENTAL APPOINTMENTS** – While we work very hard throughout the program to maintain your child's good health, we **cannot accommodate non-emergency dental care** appointments such as check-ups or tooth cleanings, etc. **If your child has cavities, routine dental needs, or tooth pain, please have this work completed prior to. If your child has braces we will not be able to accommodate any appointments dealing with tightening, cleaning, removal of braces etc…** You will be called upon to take your child to the dentist for these problems. Orthodontists should be within a reasonable distance of AZPC so any necessary orthodontist visits do not require extended time away from campus.
- **PARENT CONTACT INFORMATION** – Please provide us with any changes to your phone numbers and address immediately.
-

PLEASE SIGN AND DATE THIS FORM

Parent / Legal Guardian Signature **Date**

Thank You for helping us make your Project Challe*NG*e experience a good one. If you have any questions, please contact Project Challe*NG*e medical dept.Challe*NG*e Medical Dept. (480) 988-4100 Ext. 218/219 FAX: (480) 987-5341

SPECIAL POWER OF ATTORNEY FOR HEALTH CARE

I, ___________________________the legal guardian of_______________________________, (Child), designate and appoint the medical staff of Project ChalleNGe, Arizona National Guard, as my agent for all matters relating to the health care of my Child, including, without limitation, full power to give or refuse consent to all medical, surgical, hospital care and clinical care, psychological care or mental health. This Power of Attorney shall be effective immediately and shall last as long as the Child is a resident at Project ChalleNGe, including any period during which I am disabled or incapacitated. All of my agent's actions under this power, during any period during which I cannot be contacted for any reason, shall have the same effect upon my heirs, devises, and personal representatives as if I was available. This Power of Attorney is made under Arizona Revised Statute 14-5104 (Delegation of Powers by Guardian) and 14-5501 (when Power of Attorney not affected by disability).

The power given herein is given to assist in providing a safe environment and well being of the Child. Nothing in this document shall mean that I have given up any legal right to custody or other parental right that I may have in connection with the Child. It simply gives the Attorney in Fact power to act in my behalf as stated above.

I/we understand that Project ChalleNGe pays for Accidental Injuries only; **I/we are responsible for all medical bills for the student(s) (Doctor visits, Pharmacy, hospital/ER, X-Ray, Dental etc.)** All bills will be sent directly to me from the provider.

In additions to the waiver set out above, I/we CONSENT AND AGREE to the enrollment of our child at Project ChalleNGe, including all the elements it includes. This opportunity is accepted entirely at our own risk and at the risk of the child. In consideration of the provision of the Program thus provided, I/we release and forever discharge the Governments of the United States and the State of Arizona and employees or agents thereof acting officially or otherwise, from any and all claims, demands, actions, or cause of action, on account of any injury or illness to the child or loss of personal property which may occur from any cause during the child participation in the program, as well as all activities incident thereto.

If signed by more than one parent or guardian, this document may be read in the plural sense as to those signing.

I certify, also, that I have legal custody of the above named Child.

I HAVE READ THIS DOCUMENT AND HAD IT EXPLAINED TO ME, AND I APPROVE OF ALL THE TERMS AND CONDITIONS SET OUT IN IT.

ACKNOWLEDGEMENT – On this date before me, a Notary Public personally appeared
Applicant's Signature____

Parent/Custodial Parent/Guardian Signature____

Parent/Custodial Parent/Guardian Signature____

Known to me or satisfactorily proven to be the person whose name is subscribed to this instrument and acknowledgement that he executed the same. If this person's name is subscribed in a representative capacity, it is of the principal named in the capacity indicated.

Date_____________________NotaryPublic____

ARIZONA PROJECT CHALLENGE
PHYSICAL EXAMINATION FORM
Part A: HEALTH HISTORY QUESTIONNAIRE

(To be completed by the parent)
(This information must be completed or this form will be returned)

Date:_____________________ Date of Last Physical:____________________

Applicant's Name:____ Sex: M F (Circle One)
Age:______ Date of Birth:____________ Home Phone #:_____________________
Other Phone #:_______________ Physician:______________________________
Physician Phone#:_________________________ Fax #:_____________________

Directions: Please answer the following questions about the student's medical history. Explain all **YES** responses at the bottom of the page. Please respond to **ALL** questions.

1. Have you had or do you currently have:
   - a. A sports physical within the past 365 days? Y / N/ Don't know
   - b. An injury or illness since your last exam? Y / N/ Don't know
   - c. A chronic or ongoing illness (such as diabetes or asthma)? Y / N/ Don't know
     - Use an inhaler or other prescription medicine to control asthma? Y / N/ Don't know
   - d. Any prescribed or over the counter medication that you take on a regular basis? Y / N/ Don't know
   - e. Surgery, hospitalization or any emergency room visits? Y / N/ Don't know
   - f. Any allergies to medication? Y / N/ Don't know
   - g. Any allergies to bee stings, pollen, latex, or foods? Y / N/ Don't know
     - Type or reaction: Rash? Hives? Other skin condition? (circle)
     - Medication for reaction? (List)________________________
   - h. Any anemia or blood disorders? Y / N/ Don't know
2. Have you had or do you currently have any of the following *head-related* conditions:
   - a. Concussion requiring a physician's evaluation? Y / N/ Don't know
     - How often and when? ______________________________
   - b. Memory loss or been knocked out? Y / N/ Don't know
   - c. A seizure? Y / N/ Don't know
   - d. Frequent or severe headaches? Y / N/ Don't know
3. Have you had or do you currently have any of the following heart-related conditions:
   - a. Chest pain? Y / N/ Don't know
   - b. Heart murmur? Y / N/ Don't know
   - c. High blood pressure or elevated cholesterol level? Y / N/ Don't know
   - d. Restriction from sports for heart problems? Y / N/ Don't know
   - e. Any family member or relative:
     - Die of a heart problem before age 35? Y / N/ Don't know
     - Die of a heart problem before age 50? Y / N/ Don't know
     - Die with no known reason? Y / N/ Don't know
     - Die while exercising? During or after? (circle one) Y / N/ Don't know
     - With Mar fan's Syndrome? (connective tissues disorder) Y / N/ Don't know
4. Have you had or do you currently have any of the following eye, ear, nose, mouth or throat conditions:
   - a. Vision problem? Y / N/ Don't know
     - Wear contact, eyeglasses or protective eye wear? (circle one) Y / N/ Don't know
   - b. Hearing loss or problems? Y / N/ Don't know
     - Wear hearing aides or implants? Y / N/ Don't know

c. Nasal fractures or frequent nose bleeds? Y / N/ Don't know
d. Wear braces, retainer or protective mouth gear? Y / N/ Don't know
e. Frequent strep or any other conditions or the throat (e.g. tonsillitis) Y / N/ Don't know

5. Have you had or do you currently have any of the following neuromuscular/orthopedic conditions:
   a. A burner, stinger, or pinched nerve? Y / N/ Don't know
   b. A sprain? Y / N/ Don't know
   c. A strain? Y / N/ Don't know
   d. Swelling or pain in muscles, tendons, bones, or joints? Y / N/ Don't know
   e. A dislocated joint(s)? Y / N/ Don't know
   f. Upper or lower back pain? Y / N/ Don't know
   g. Fracture(s) or stress fracture(s)? Y / N/ Don't know
   h. Do you wear any protective braces or equipment for any prior injury? Y / N/ Don't know
6. Have you had or do you currently have any of the following general or exercise related conditions:
   a. Difficulty breathing? During exercise? (circle) Y / N/ Don't know
      - After running on mile? Y / N/ Don't know
      - Coughing, wheezing or shortness of breather in weather changes? Y / N/ Don't know
      - Exercise-induced asthma Y / N/ Don't know
         - Controlled with medication? List____________________ Y / N/ Don't know
         - Experience dizziness, passing out or fainting? Y / N/ Don't know
   b. Viral infections (e.g. mono, hepatitis)? Y / N/ Don't know
   c. Become tired more quickly than your friends? Y / N/ Don't know
   d. Any of the following skin conditions?
      - Acne, contact dermatitis, ringworm, warts, herpes? Y / N/ Don't know
      - Sun sensitivity? Y / N/ Don't know
   e. Weight gain/loss (greater than or less than 10 lbs)? Y / N/ Don't know
      - Do you want to weight more or less then you do now? M / L
   f. Ever had feelings of depression? Y / N/ Don't know
   g. Psychiatric diagnosis? Y / N/ Don't know
   h. Inpatient psychiatric facility? Y / N/ Don't know
   i. Heat-related problems (dehydration, dizziness, fatigue, headache)? Y / N/ Don't know
      - Heat exhaustion (cool, clammy, damp skin)? Y / N/ Don't know
      - Heat stroke (hot, red, dry skin)? Y / N/ Don't know

7. **FEMALES ONLY**:
   a. Age on onset of menstruation:___________________________________
   b. Date of last menstruation:_______________________________________
   c. Most number of days between menstruation cycle (s):________________

Explain all YES answers here (include relevant dates):
____
____
____
____
____

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature. **Lying or withholding information on this questionnaire could result in your child's termination from the program.**

Parent/Guardian Signature:____Date:____________________

ARIZONA PROJECT CHALLENGE
PHYSICAL EVALUATION FORM
Part A: Physical Examination

(To be completed by examining physician)

Examination Date:______________________________

Applicant's Name:____ Sex: M F (Circle One)
Age:______ Date of Birth:________________
Address:____
City/State/Zip:____ Home Phone #:_____________________
Parent/Guardian's Full Name:____

PHYSICIAN INFORMATION

Name:______________________________ Phone:__________________ Fax:_____________________
Address:_______________________________ City/State Zip:______________________________________

EVALUATION INFORMATION -PLEASE COMPLETE BOTH PAGES

Height:_____________ Weight:______________ Blood Pressure:________/_________ Pulse:_____bpm.

INDICATORS	NORMAL? Y OR N	ABNOMAL FINDINGS/COMMENTS
Head/Neck		
Eyes/Sclera/Pupils		
Ears		
Nose/Mouth/Throat		
Heart: Murmurs/Rhythms		
Lungs: Auscultation/Percussion		
Chest Contour		
Skin		
Abdomen: Assessment (incl. liver, spleen)		
Tanner Stage: Testes/Onset of Menses		
Neck/Back/Spine: Range of Motion:		
Scoliosis:		
Upper Extremities:		
Lower Extremities:		
Neurological: Balance/Coordination: Romberg:		
Heel Walk:		
Tandem Walk:		
Nose Touch:		
Toe Walk:		
Hernia:		

Most recent immunizations and the dates:
Medications currently being used:
Additional Observations:

General Diagnosis:____

Recommendations:____

CLEARANCES

Applicant MAY participate in the following sports: (Check ALL that apply)

________Contact/Collision _______Non-Contact/Strenuous

________Limited Contact _______Non-Contact/Non-Strenuous

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT			
Contact/Collision	Limited Contact	Non-Contact	
		Strenuous	Non-Strenuous
Football	Baseball	Running	
Soccer	Basketball	Marching	
Wrestling	High Jump	Push-up	
	Gymnastics	Sit-up	
	Softball	*Strength Training	
	Volleyball	Swimming	
		Track	

Applicant MAY participate in the following sports: ONLY AFTER completing evaluation/rehabilitation:

________Contact/Collision _______Non-Contact/Strenuous

________Limited Contact _______Non-Contact/Non-Strenuous

Please specify each condition requiring clearance before participating in a sport in the classification check above:____

Conditions requiring clearance before sports participation include, but are not limited to: Atlantoaxial instability, Bleeding disorder, Hypertension, congenital heart disease, Dysrhythmia, Mistral valve prolepses, Heart murmur, Cerebral palsy, Diabetes mellitus, Eating disorders, Heat illness history, One-kidney athletes, Hepatomegaly, Splenomegaly, Malignancy, History of repeated concussion, Organ transplant recipient, Cystic fibrosis, Sickle cell disease, and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.

EXAMINED BY:

Family Physician/Provider (Circle one)

___MD ___DO___NP___PA

Physician's/Provider's Stamp:

Physician's/Provider's Signature:____Date:__________

NOTE: The physician shall provide written notification to the parent/legal guardian stating approval or disapproval of the student's participation in Arizona Project ChalleNGe based on this medical report. Please attach this form to the notification letter and ensure that this report is made part of the student's permanent health record.