

Applicant's Name: _____

**Texas ChalleNGe Academy
Medical Screening Form**

Dear Physician

Please read program description and review applicant's medical history prior to the examination.

The program training can be physically demanding and potentially dangerous. Physical training will include such physically strenuous activities as:

1. A daily run of two or more miles on a hilly course.
2. Daily vigorous physical exercises.
3. A ropes/obstacle course in which participants may:
 - a. Climb a pole and then leap out from the pole and grab a hold of a trapeze (which may involve a slight jerk), and then be lowered to the ground in a safety harness,
 - b. Two people facing each other on V-shaped tight ropes 20-30 feet in the air, with hands interlocked above their heads sidestepping across as their bodies become farther and farther apart
 - c. Climb a 15 foot wall while being assisted by other course participants to get up, over and down the wall,
 - d. A "zipline", with an abrupt stop at the bottom.

MEDICAL HISTORY/EXAMINATION INFORMATION

This examination is for determining fitness to engage in strenuous activities as outlined above. The exam must be performed within six (6) months of the first day of the class start date.

FILL OUT THE FORM COMPLETELY AND ACCURATELY. EVERY LINE MUST BE COMPLETED. ANSWER N/A IF A QUESTION IS NOT APPLICABLE.

Any questions concerning this examination or your patient's ability to participate may be directed to the TCA Staff Nurse at 432-836-1526. All applicants must have a vision exam and drug test completed prior to acceptance.

PLEASE RETURN THE COMPLETED FORM TO:

Texas ChalleNGe Academy
Attn: Screening Coordinator
PO Box 510
Sheffield, TX 79781

CONSENT FOR MEDICAL CARE

STUDENT INFORMATION:

Name: _____ Date of Birth: _____ SSN: _____

Address: _____

City County State Zip Home Phone

Parent Work Phone Parent Cell Phone Parent E-Mail Address

I hereby grant permission to Texas ChalleNGe Academy to provide medical care for my son/daughter. If my son/daughter needs emergency medical/dental attention due to an accident or injury, I hereby authorize the attending medical/dental personnel at the Emergency Facility to provide whatever treatment is necessary to include but not limited to x-rays, anesthesia, diagnostic procedures, medical procedures, dental procedures and/or interventions. In the event of an emergency illness or injury, I understand that reasonable effort will be made to contact me. Reasonable effort means that I may not be contacted first but will be contacted as soon as possible by the staff from TCA. I understand that Texas ChalleNGe Academy has a full time Nurse and a full time assistant to the Nurse and that this may be an **EMT** (Emergency Medical Technician) or a **CNA** (Certified Nurse Assistant). I grant permission for any of the Medical Staff, Certified Military Medic Team Leaders, and Team Leader in Charge to dispense medication to my son/daughter. This medication may be a prescription which has been prescribed directly to my son/daughter by a physician or it may be over the counter medication as deemed necessary by TCA. **My son/daughter is allergic to the following:**

It is further understood that Texas ChalleNGe Academy carries medical insurance for accidental injuries only. Medical care outside the scope of Texas ChalleNGe Academy Medical Staff will be the financial responsibility of the parent or legal guardian. The Medical Staff will determine the need for my son/daughter to be seen by a physician if necessary. My insurance information is listed below:

Medical Insurance Company: _____ Phone # for Certification: _____

Policy Holders Name: _____ Policy or Group #: _____

Medicaid or CHIPS #: _____

Emergency Contact Information in The Event Parent or Guardian Cannot be Reached

Name: _____ Relationship: _____

Address: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

I have read and understand all of the above and to the best of my knowledge the information supplied is true and correct.

Signature of Parent or Guardian

Signature of Applicant

Witness Signature: _____

MEDICAL HISTORY

Are you currently using any **prescribed** medications? YES _____ NO _____

If yes, Please list all medications and dose and time:

Medication	Mg	Dosage	Why	How Long Have You Been Taking This Medication

Are you allergic to any medications, foods, or other agents such as bee stings, ragweed etc.? YES _____ NO _____

If yes, please list the agent and the way you react to it:

Allergen	Reactions	What Do You Do?

Have you ever been a patient in a hospital? YES _____ NO _____

If yes, please list the date, hospital and reason:

Mo/Yr	Hospital	Reason

Have you ever been treated for (circle all that apply):

Mental Problems ADHD Bipolar Depression Conduct Disorder

Oppositional Defiant Disorder Obsessive Compulsive Disorder

Suicide Attempts? Yes No If Yes, Date: _____

Rehab for Drug or Alcohol Abuse? Yes No If Yes, Date: _____

Have you ever used: Marijuana _____ Crack _____ Cocaine _____ Heroin _____ Other _____

How often do you drink alcohol? Daily Weekly Monthly Special Occasions

Alcohol of Choice: Beer Wine Liquor

Do you smoke or use Tobacco products? Yes No How Often? _____

Do you wear (circle one) glasses or contact lenses? Date of last vision exam: _____

Do you have, or have you ever had any of the following:

	NO	YES			NO	YES	
1.			Headaches, Migraines or Clusters	23.			Diabetes/Hypoglycemia
2.			Severe Head Injuries	24.			Thyroid Problems
3.			Loss of Consciousness	25.			Kidney/Urinary Problems
4.			Seizures/Convulsions	26.			Intestinal Problems
5.			Heart Disease/Murmurs/Irregular HB	27.			Bedwetting (since age 14)
6.			Chest Pain	28.			Severe Acne
7.			High Blood Pressure	29.			Frequent Stomachaches/Ulcers/Reflux
8.			Circulation Problems	30.			Staph Infection
9.			Anemia/Sickle Cell/Blood Disorder	31.			Athletes Feet/Skin Fungus
10.			Unexplained Sweating	32.			Cold/Heat Intolerance
11.			Dizziness/Fainting Spells	33.			Allergies
12.			Neck and/or Back Problems	34.			Tuberculosis/Positive TB Test
13.			Scoliosis	35.			Depression/ADHD/Bipolar
14.			Muscle Cramps	36.			Mental Illness/Psychological Disorder
15.			Pins/Screws/Rods	37.			Hearing Impairment
16.			Flat Feet	38.			Communicable Diseases
17.			Broken Bones	39.			Adverse Reaction to Drugs
18.			Arm/Shoulder Problems				FEMALES ONLY:
19.			Hip/Knee/Ankle/Foot Problems	40.			Heavy or Difficult Menstrual Cycle
20.			Wheezing/Asthma/Shortness of breath	41.			Untreated Abnormal Vaginal Discharge
21.			Anorexia/Bulimia	42.			Are you Pregnant?
22.			Hepatitis/Liver Problems				

All yes responses must be explained by number. You may use the back of this page if necessary.

Applicant's Name: _____

PHYSICIAN'S EXAMINATION

Age: _____ Height: _____ Weight _____ Pulse: _____ BP: _____

Glasses: Yes ___ No ___ Color Vision: _____

Right: 20/ _____ Corrected 20/ _____ Left: 20/ _____ Corrected 20/ _____

Normal	Physical Examination	Abnormal	Comments
	Head, Face, Neck, Scalp		
	Nose		
	Sinuses		
	Mouth and Throat		
	Ears – General		
	Eardrums		
	Eyes – General		
	Pupils		
	Ocular Motility		
	Lungs and Chest		
	Heart		
	Vascular System		
	Abdomen/Viscera		
	GU System		
	Upper Extremities		
	Feet		
	Lower Extremities		
	Spine		
	Identifying Body Marks		
	Skin/Lymphatic System		
	Neurological System		
	Psychiatric		

As the attending physician, I have reviewed the medical history of the above named applicant. I have also read the cover letter addressed to me explaining the program. I have conducted a complete sports physical and have found the applicant to **be** physically capable to participate completely in all strenuous activities with no limitations.

Additional comments may be written on the back of this form.

(PRINT) Physician's Name

Physician's Signature

Address

City State Zip Code

Date of Exam

() _____

Phone Number

Applicant's Name: _____

DRUG SCREENING

A physician, nurse or certified drug tester must screen every applicant to Texas ChalleNGe Academy for the drugs listed below. The testing official must complete this form and forward the results to the TCA nurse by fax (432-836-4649), mail (phone & address on page 1) or e-mail to sharon.hart@isisd.net.

The Texas ChalleNGe Academy is a drug free program. The results of this test **will not** eliminate applicants from being accepted into the program. The purpose of this test is to serve notice to applicants that TCA has a zero tolerance policy towards the illegal use of drugs. Every applicant that is accepted **will be tested again** when they report for the first day of the class.

As an applicant to Texas ChalleNGe Academy I certify that I am voluntarily submitting to drug screening for the purpose of attending the National Guard Youth Challenge Program. I authorize the drug testing official to release the results of the urinalysis to the Texas ChalleNGe Academy staff nurse.

Signature of Parent or Guardian

Signature of Applicant

Date of Urinalysis: _____

<u>Substance</u>	<u>Test Result</u>	<u>Nanograms</u>
THC	+ or --	_____
Cocaine	+ or --	_____
Methamp	+ or --	_____
Benzodiazepines	+ or --	_____
Opiates	+ or --	_____

Note: **Nanograms** identify how much of the substance is in the system. Students will not be considered for admission without the nanogram results for **all positive substances.**

(PRINT) Testing Official's Name

Testing Official's Signature (_____) _____
Phone Number

Address City State Zip Code