HAWAII NATIONAL GUARD
YOUTH CHALLENGE ACADEMY – HILO CAMPUS
PO Box 5210 Hilo, HI 96720
Phone (808) 430-4184
Fax (808) 933-1403
admissions.hilo.yca@hawaii.gov

Congratulations on your decision to apply to the Youth Challenge Academy Hilo Campus!
There are a number of items that need to be completed, to help we have provided a simple checklist.

- ☐ Application – completed and signed by candidate and all custodial parents/guardians

- ☐ Birth Certificate – copy
- ☐ Medical Insurance Card - copy
- ☐ Social Security Card - copy
- ☐ Government issued ID - copy

- ☐ Enrollment Agreement (Completed/Signed by applicant and all custodial parents/guardians are sent back to YCA)
- ☐ Parent Questionnaire, Custody, 911 Contact form (Completed/Signed by all custodial parents/guardians are sent back to YCA)
- ☐ Waivers (Completed/Signed by all custodial parents/guardians are sent back to YCA)
- ☐ Family Tree Project (Completed/Signed by applicant and all custodial parents/guardians are sent back to YCA)

- ☐ Medical Aid Station, Rx (Completed/Signed all custodial parents/guardians are sent back to YCA)
- ☐ Medical Provider forms (Please fill out parent/guardian sections ONLY, then bring to medical appointments. Completed/Signed forms are sent back to YCA)

- ☐ Juvenile Criminal Report (This is *REQUIRED* for all applicants. Requests are processed at your district Family Court, results are sent back to YCA)

- ☐ Transcript Requests (Complete and submit to current/previous school attended)

- ☐ Mentor Application (Due to our Post Residential Team no later than In-Processing Day) *Mentors can expect to fill out the application, obtain two referrals, participate in a phone interview with our Post Residential Team, submit fingerprints, and complete training.

All required items should be completed and returned to our office by email, fax, mail, or online submission 2 weeks prior to the beginning of class, however if you run into setbacks and need additional time please communicate to our offices as early as possible.

HAWAII NATIONAL GUARD
YOUTH CHALLENGE ACADEMY – HILO CAMPUS
Frequently asked questions & Important Information

1. Can we use a school ID?
   No. It is a requirement of the program to have a government issued ID. Acceptable forms of ID include State, Driver License, Permit, Military, Passport.

2. My child doesn't have a criminal history, do we still need to obtain the report?
   Yes. This is required of all applicants.

3. My child takes prescription medications.
   Any prescribed medication and dosages must be accompanied by medical documents and a 90-day supply upon enrollment.

4. My child got a physical, TB test, or dental exam this year, can I use it?
   Yes. Clearances completed within 1 year of enrollment are accepted.

5. Can I withdraw my child from school now?
   No. 4140 forms are processed after Acclimation Graduation.

6. Is there a fee?
   No. Families are responsible for the items on the supply list.

7. Does YCA provide transportation for neighbor island applicants?
   Yes. We arrange and pay for your child's arrival as well as their flight home upon graduation. Please note that if your child is discharged for any negative behavior, or voluntarily drops out from the program, to include parental removal, you will be responsible for air fare home.

8. How many times will families be able to visit?
   Twice, Family Day and Graduation. Family, friends, and mentors are strongly encouraged to write to their applicant as often as possible. Phone calls happen regularly after the Acclimation Phase of the program.

9. We are having a difficult time finding a suitable mentor.
   Please contact our Post Residential office at (808) 896-8228 to further discuss.

10. Required parent participation:
    Upon acceptance, a parent/guardian, will be required to attend a workshop each month to maintain a connection to their cadet and the academy staff to help facilitate change each cadet is seeking through participation in the YCA program.

HAWAII NATIONAL GUARD YOUTH CHALLENGE ACADEMY

APPLICATION

HAWAII ISLAND & MAUI COUNTY

(808) 430-4184 admissions.yca.hilo@hawaii.gov

SSN#: PROVIDE COPY	LEGAL NAME: FAMILY/LAST	FIRST/GIVEN	FULL MIDDLE
_ _ _ / _ _ / _ _ _ _			

STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE AND EMAIL
				Cell:
MAILING ADDRESS *(If same as above check here)* ☐	CITY	STATE	ZIP CODE	Home:
				Email:

GENDER	BIRTHDATE	AGE	EMPLOYED?	US CITIZEN?	ATTACH COPY OF GREEN CARD	
☐ FEMALE	MOS / DAY / YEAR			☐ YES	☐ VISA ☐ I-94	Other:
☐ MALE	/ /			☐ NO	☐ PERMANENT RESIDENT	

Racial Background: ☐ American Indian ☐ Alaskan Native ☐ Asian ☐ African American/Black ☐ American Samoan ☐ Filipino ☐ Gumanian/Chamorro ☐ Hawaiian ☐ Micronesian ☐ Pacific Islander ☐ Samoan ☐ White ☐ Hispanic

Mother's *(Female Guardian)* **Information**

Last, First Name	Relationship	Email	Phone

STREET ADDRESS	CITY & STATE	ZIP CODE

Racial Background: ☐ American Indian ☐ Alaskan Native ☐ Asian ☐ African American/Black ☐ American Samoan ☐ Filipino ☐ Gumanian/Chamorro ☐ Hawaiian ☐ Micronesian ☐ Pacific Islander ☐ Samoan ☐ White ☐ Hispanic

Father's *(Male Guardian)* **Information**

Last, First Name	Relationship	Email	Phone

STREET ADDRESS	CITY & STATE	ZIP CODE

Racial Background: ☐ American Indian ☐ Alaskan Native ☐ Asian ☐ African American/Black ☐ American Samoan ☐ Filipino ☐ Gumanian/Chamorro ☐ Hawaiian ☐ Micronesian ☐ Pacific Islander ☐ Samoan ☐ White ☐ Hispanic

ACADEMIC DECLARATION

LIST EVERY HIGH SCHOOL (PUBLIC/PRIVATE/CHARTER/HOME) ATTENDED INCLUDING THE ONE CURRENTLY ENROLLED IN, IF ANY

MOST RECENT SCHOOL /PROGRAM (DO NOT USE ABBREVIATIONS)	CITY/STATE/COUNTRY	ATTENDED/ATTENDING FROM M/Y	TO M/Y

PERSONAL STATEMENT ESSAY (ATTACH PAPER AS NEEDED)

1. I would like to go to Youth Challenge because…

2. My future goal is to…

Referral Information

First Name	Last Name	Phone	Relationship
Organization	**Referral Date**	**Email**	**Occupation**

CONTINUE ON REVERSE SIDE

RESIDENCY DECLARATION (Submit Government-Issued Identification)

I am a legal resident of Hawaii based on:

- ☐ I was born in the United State or one of its Territories.
- ☐ Naturalized U.S. Citizen
- ☐ Assigned to Hawaii by a U.S. federal agency (i.e. the Military)
- ☐ Legal Residency Card (I-94)

LEGAL DECLARATION (Submit Abstract/Letter of Clearance)

☐ I have never been arrested

☐ I have been arrested in the past When? _____ For What: _____

☐ I am on probation for Juvenile Status. Probation Officer's Name: _____ Phone: _____

☐ I have pending cases against me. My court date is set for: _____ Charge: _____

ALCOHOL AND DRUG FREE DECLARATION (Submit Academy-Approved Drug Test)

By my initials, I understand that the Hawaii National Guard Youth Challenge Academy, (YCA) is and Alcohol, Tobacco and Drug free environment, with a Zero Tolerance policy against drug use. I understand that I will be subject to random drug and toxicology screenings at any time while attending YCA and if I am found to test positive for substance abuse or am caught in possession of any of the aforementioned substances, I may be dismissed from YCA immediately without notice.

Init _____

MEDICAL DECLARATION (Submit Medical Physical Clearance within 12 months)

By my initials, I understand that the YCA is physically, emotionally, and mentally demanding and that it is my responsibility to inform the YCA staff of any pre-existing medical issues or concerns prior to my being accepted into the YCA program. To ensure that I am physically prepared for the YCA, I am required to complete a standard Hawaii DOE sports physical and provide a copy of that physical to the YCA admissions staff. Also, upon my reporting to the YCA, I am required to turn over all prescribed medications and accompanying documentation to the YCA medical staff who will monitor my use of this medication in accordance with all physician's written guidelines.

Init _____

MENTOR PROSPECT

I understand that I am required to find a mentor to assist me in completing YCA program. This mentor must be at leaset 23 years old, the same gender as myself, cannot live in my household, cannot be a parent or grandparent and must pass a criminal background check. This mentor must commit to attending an 8-hour training session and be willing to visit with me at least once a week during the 3rd and 4th months of the YCA residential program. Upon my graduation, this mentor will be required to submit weekly reports on my progress towards achieving my life goals as etablished during the residential portion of the YCA program.

By my initials, I understand that I may be discharged if I do not provide a trained mentor by week 13.

Init: _____

Mentor Prospect 1:

NAME: _____ GENDER: _____ DOB: ____ / ____ / ____ MARITAL STATUS: **M S D W**

RELATIONSHIP TO YOU: _____ CONTACT INFO: _____

Mentor Prospect 2:

NAME: _____ GENDER: _____ DOB: ____ / ____ / ____ MARITAL STATUS: **M S D W**

RELATIONSHIP TO YOU: _____ CONTACT INFO: _____

APPLICATION CERTIFICATION

I am VOLUNTARILY enrolling in the Hawaii National Guard Youth Challenge Academy Hilo Program. I understand that this is not a "sentencing alternative", and I can't be court ordered to attend. I also understand that the YCA Hilo is not OBLIGATED to accept me into the program.

☐ Yes ☐ No

I certify that the responses provided on this Application Form are complete and true to the best of my knowledge and belief. **I understand that providing incomplete, incorrect, or false information may result in the rescission or denial of my admission.** I agree to provide documents relevant to the determination of my residency status and age as required by national Guidelines. Furthermore, I understand that the YCA shares a common database and personal information may be accessed by authorized Academy and National Guard Personnel.

Date: _____ Applicant's Signature: _____

If Applicant in under 18

Date: _____ Parent/Guardian's Signature: _____

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HAWAII NATIONAL GUARD YOUTH CHALLENGE ACADEMY ENROLLMENT AGREEMENT

"THIS INSTITUTION IS AN EQUAL OPPORTUNITY PROVIDER"

PLEASE KEEP A COPY FOR YOUR RECORDS.

In consideration of the mutual agreements hereafter set forth, faithfully, to be fully kept and performed by the respective parties hereto, it is agreed as follows:

Term 1. Term Set for Contract – I understand that the Hawaii National Guard Youth Challenge Academy (YCA) is a Residential Program and understand that all cadets must be in attendance for a required number of days. Cadets who fail to complete the required number of training days may become ineligible to complete/graduate the program. Dates of enrollment are set per class to cover the required number of training days as set forth in the memorandum of agreement with the National Guard Bureau.

Parent/Guardian Initials _____ /_____ Cadet Initials _____

Term 2. Conditions of Enrollment – I understand and agree that YCA retains the right to suspend or dismiss a cadet from YCA for conduct (on or off campus) that is prejudicial to the good order and discipline required by YCA, or for any violation of the YCA rules and regulations as set forth in the Cadet Student Manual. YCA bears no obligation to provide any academic work to complete a semester or any academic credit once a cadet is dismissed. All cadets are furnished with a copy of these regulations to which they will be bound and ordered to both review and understand them fully.

Reasons for possible dismissal include but are not limited to the following:

- Drugs & Hallucinogens—Selling, Possession, Use and/or Distribution of Drug Paraphernalia.
- Refusing to take a Urine Drug Screen/Breathalyzer Test
- Positive Results on a Urine Drug Screen/Breathalyzer Test
- Alcohol and/or Beer – Use of and/or Possession.
- Civil Law Violation Inside/Outside YCA
- Lying, Stealing, or Cheating of **ANY** Kind, On or Off Campus
- Physical or mental hazing of any kind
- Repeated Fighting in Barracks/on Campus
- Moral or Lewd Misconduct
- Vandalism – Willful Destruction of School Property (Room/Barracks, etc.)
- Making Unauthorized Telephone Calls
- Excessive Demerits/Class Absences
- Threatening YCA Faculty, Staff or Cadre
- Unauthorized Personnel in Cadet Barracks at **ANYTIME**.
- Offenses affecting the Well Being of the YCA
- Female Cadet in Males' Room/Barracks or Male Cadet in Females' Room/Barracks
- Possession of Guns; Knives; Stun Guns; Paint Ball Guns, Rocket Fuel or Flammable Materials
- Self-Inflicted Wounds to include Tattoos/Branding, and/or Body Piercing
- Possession of Unauthorized Keys
- Leaving Facility without Permission
- Sexual Harassment of **ANY** Kind
- Racial Remarks of **ANY** Kind
- Gambling; Possession of Gambling Paraphernalia
- Stealing from YCA staff offices/desks/vehicles/purses, etc.
- Violation of the Tobacco use policy

Parent/Guardian Initials _____ /_____ Cadet Initials ____

Term 3. YCA Drug Policy – I understand that every cadet will be given a urinalysis (UA) within 40-days of arrival at YCA and will be subject to random testing while enrolled at YCA. Anytime a UA result is positive, the parent or guardian has the right to request a second UA test be conducted at their own expense before the cadet is dismissed from the program. YCA will maintain physical custody of the cadet during this entire process.

Parent/Guardian Initials _____ /_____ Cadet Initials _____

Term 4. Sexual Harassment – I understand and agree that all cadets are required comply with YCA policies prohibiting any form of sexual harassment. I understand that if a cadet sexually harasses any other cadet, staff member or YCA volunteer they may be subject to immediate disciplinary actions. YCA Disciplinary actions include, but are not limited to, the loss of rank and/or position, being placed on a disciplinary detail, loss of favors or dismissal from the program. This policy does not limit or interfere with the potential for civil or criminal charges being brought by the victim.

Parent/Guardian Initials _____ /_____ Cadet Initials _____

Term 5. Conditions for Authorized Leave – I understand that cadets may be released from the academy on a temporary basis for any one or both of the following purposes: Wedding of Parent or Guardian or Death of Immediate Family Member (Parent or Guardian, Sibling, Grandparent or Great-Grandparent only) either Biological or Adopted. Released cadets must return within the designated time frame as determined by YCA to be appropriate for said event. Any deviations from course will result in possible disciplinary actions which may include, but are not limited to, the loss of rank and/or position, being placed on a disciplinary detail, loss of favors or dismissal from the program.

Parent/Guardian Initials _____ /_____ Cadet Initials _____

Term 6. Academic Program – I understand that cadets will earn three credits while enrolled at YCA. It is at the discretion of the cadet's academic institution to allow said credits to be transferable. Upon successful graduation from YCA, graduates will receive a Certificate of Program Completion from YCA. They will also receive either a High School Equivalency Diploma utilizing the High School Equivalency Diploma Program, or a Workforce Development Diploma. The Workforce Development Diploma Program provides an opportunity to gain the knowledge, skills and abilities needed for employment and/or job training. Future requests for transcripts or copies of diplomas must be made through the Waipahu Community School for Adults, Hilo Campus.

Parent/Guardian Initials _____ /_____ Cadet Initials _____

Term 7. Media Policy – Unless specifically forbidden by the responsible enrolling party, it is YCA's policy that enrollment is deemed as consent to the photographing, videotaping and voice recording of cadets for use singularly or in conjunction with other images and/or recordings for advertising, publicity, commercial or other business purposes in markets both foreign and domestic. -YCA policy states that unless specifically forbidden by the responsible enrolling party, all responsible parties release YCA, and any of its affiliated organizations, their directors, officers, agents, employees, customers, and appointed advertising agencies from all claims of any kind on account of such use.

Parent/Guardian Initials _____ /_____ Cadet Initials ____

Term 8. <u>Financial Responsibility</u> – Although YCA has no registration fees or established program costs, I acknowledge by my initials below that any undue expenses incurred by YCA as a result of damage, misuse of facilities or any other unforeseen circumstances due to negligence will be reimbursed by me as soon as possible upon receipt of such charges. All incomplete or non-paid fiscal responsibilities may result in cadet termination, suspension of training or withholding of graduation documents. In the event that recovery of financial obligations requires legal action, I agree to pay all collection expenses incurred by YCA to include court costs and attorney's fees, without relief from valuation or appraisement laws.

1. All payments must be made in money order or cashier's check, to the YCA and all fiscal responsibility concerns may be directed to the YCA business office, the Deputy Director for the appropriate academy or the Director of YCA.

When deemed necessary by YCA or their affiliates, a credit investigation of the parent and/or responsible party is authorized for the purpose of obtaining necessary financial information.

Parent/Guardian Initials _____ /_____ Cadet Initials _____

Term 9. <u>Transportation Policy</u> – I understand that cadets participate in organized off-site events for medical appointments, educational field trips and other training or functions. All off-site training missions are conducted with the highest regard for the safety and the well-being of each cadet in accordance with YCA and NGB standards. While participating in any off-site training/functions, cadets are required to follow all rules of conduct as specified in the YCA's rules and regulations SOP and the Cadet Student Manual. By enrolling in the YCA, I give consent to allow participation in all YCA sanctioned off-site training, and agree to voluntarily release and forever discharge YCA, its employees, agents, representatives, and volunteers from any and all claims of liability or damages incurred as a result there of, from the time of departure to the time of return to YCA facilities. It is understood that nothing in this policy is intended to, nor shall it be construed to, release any insurance company or third party agency from any obligation to pay under any liability insurance or other benefit.

Parent/Guardian Initials _____ /_____ Cadet Initials _____

Term 10. <u>Athletics Participation Policy</u> –All cadets are expected to participate in organized and intramural athletics while attending YCA. By the initials below, I acknowledge that injuries are a possibility, which could result in a permanent disability, paralysis or even death. Unless noted on the required physical examination form, cadets and/or parents/guardians attest and verify that the identified cadet is in good physical health and is capable of participating in such activity. By enrolling in the YCA, I give consent to allow participation in all YCA physical activities and agree to voluntarily release and forever discharge YCA, its employees, agents, representatives, and volunteers from any and all claims of liability or damages incurred as a result there of, whether on or off of YCA property. It is understood that nothing in this policy is intended to, nor shall it be construed to, release any insurance company or third party agency from any obligation to pay under any liability insurance or other benefit.

Parent/Guardian Initials _____ /_____ Cadet Initials _____

Term 11. <u>Occupational Welfare Policy</u> – Program participants receive training under program guidelines established by the National Guard Bureau, the Hawaii Department of Defense and the Hawaii Department of Education, however, cadets are not considered employees nor members of any of the aforementioned organizations. In regards to computing compensation benefits for a disability or death incurred while attending the YCA, participants shall be considered Federal employees under Subchapter I of Chapter 81 of Title 5, U.S. Code, for the purpose of compensation for work injuries; and for the purpose of Sections 1346(b) and Chapter 171 of Title 28, U.S. Code, and any other provision of law relating to the liability of the United States for tortious conduct of employees of the United States and shall, if granted, receive compensation under the entrance salary for a grade GS-2 federal employee.

1. The participants shall not be considered to be in the performance of duty while not at the assigned location of training or if they are found to be in violation of any program agreements or standing orders.

2. The entitlement of a person to receive compensation for a disability shall begin on the day following the date that the person's participation in the Program is terminated.

Parent/Guardian Initials _____ /_____ Cadet Initials _____

Term 12. <u>Representation or Warranties</u> – I understand that there are no representations or warranties upon which I have relied in deciding to enroll my cadet in the YCA, except as specifically contained within this agreement or written documents to which it may refer.

Parent/Guardian Initials _____ /_____ Cadet Initials _____

Term 13. <u>Permission Statement</u> – By my initials below, I hereby grant consent for YCA to provide my parent(s)/legal guardian(s) or sponsor(s) any information regarding academics and all other aspects of my involvement in the YCA program.

Cadet Initials _____

Term 14. <u>Legal Contract to Enrollment Agreement</u> – YCA and the undersigned parties are bound by the provisions of this Enrollment Agreement and all other written and signed agreements with YCA and terms contained therein as governed by the laws of the State of Hawaii and the National Guard Bureau. This agreement cannot be changed or modified without a mutually signed agreement between all parties involved.

CANDIDATE SIGNATURE	**DATE**
PARENT/GUARDIAN SIGNATURE	**DATE**
PARENT/GUARDIAN SIGNATURE	**DATE**

PARENT/GUARDIAN INTERVIEW QUESTIONNAIRE

NAME: _____ (Check One) Parent:☐ Guardian:☐

APPLICANT NAME: _____ **Age of today:** ___ **Gender:** ___

FAMILY:

1. Are there any family dynamic issues we should be aware of (e.g. family members he/she should not be seeing nor having any correspondence with and why? _____
_____
_____
_____

2. How is your child at home? How's the relationship between child and other family members?
_____
_____
_____
_____

3. Does your child engage in helping with chores? Does your child have a curfew? If not, why?
_____
_____
_____

4. Are you in control of your child when it comes to discipline? Explain: _____
_____
_____
_____

5. Why would your child be interested in Youth Challenge Academy? Or is it you? Explain: ____
_____
_____
_____

FAMILY INCOME (for statistics):

Less than $15,000 ☐	$15,000-$25,000 ☐	$25,000-$35,000 ☐	$35,000-$45,000 ☐	Over $45,000 ☐

SCHOOL:

1. Does your child have any special needs that we should be aware of? IEP/504? _____
_____
_____

2. What is your child's academic strength and or interest (e.g. math, reading, writing, etc.) Explain: _____
_____
_____

3. What type of characteristic does your child have (e.g. shy, talkative, opinionated, helpful, etc.) Explain: _____
_____
_____

LEGAL:

1. Does your child have a Probation Officer? If yes, why? _____
_____
_____
_____
_____

2. Does your child have any pending charges or court dates? If yes, what is it and when? _____
_____
_____
_____
_____

3. Probation Officer name and contact information:
_____

SELF:

1. Does your child have a boyfriend or girlfriend? If yes, list their name: _____
_____

2. Do you know of your child knows someone in the program or has applied for next cycle? If yes, please state name and information: _____
_____

3. Do you have any relatives applying for next cycle or friends of the family? If yes, please list the names: _____
_____

4. Is there any concerns you would like to share about your child that we haven't asked you? Everything that is shared is confidential: _____
_____
_____
_____

SURVEY:

How did you hear about HINGYCA: _____
What do you think about HINGYCA: _____
Would you recommend HINGYCA to others: _____
What district are you from: _____

By signing below, you have agreed that all answers given in the nest of you knowledge and honesty and should any information is falsified, your child will not be considered an applicant for this program. Any questions or concerns please address it at this time.

_____ _____

PRINT FULL NAME OF PARENT/GUARDIAN **DATE**

_____

SIGNATURE OF PARENT/GUARDIAN

HAWAII NATIONAL GUARD YOUTH CHALLENGE ACADEMY

CUSTODY INFORMATION

CADET LAST NAME: _____

CADET FIRST NAME: _____

CADET DATE OF BIRTH: _____ / _____ / _____

CADET SOCIAL SECURITY NUMBER: _____ - _____ - _____

CADET IDENTIFYING MARKS (Scars, Birthmarks, Tattoos, etc.): _____

_____

Primary Nationality	Gender	Height	Weight	Hair Color	Eye Color

CUSTODIAL PARENT(S)/GUARDIAN (S)*: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ BUSINESS PHONE: _____

SECOND PARENT(S)/GUARDIAN(S)*: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ BUSINESS PHONE: _____

SECONDARY CONTACT: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ BUSINESS PHONE: _____

RELATION TO CADET: _____

If you complete the 2nd Parent information, please mark yes or no to the following questions.

1. PLEASE SEND MAILINGS CONCERNING CADET INFORMATION & GRADES: YES _____ NO _____
2. SECOND PARENT IS ALLOWED VISITATION AT THE ACADEMY ONLY: YES _____ NO _____
3. SECOND PARENT IS ALLOWED FULL PASS PRIVILEGES: YES _____ NO _____

**Note: In cases of divorce we will require a copy of legal custody paperwork.*

"THIS INSTITUTION IS AN EQUAL OPPORTUNITY PROVIDER"

HAWAII NATIONAL GUARD YOUTH CHALLENGE ACADEMY
EMERGENCY CONTACT INFORMATION

CANDIDATE: _____

PARENT/LEGAL GUARDIAN:

	FATHER/MALE GUARDIAN	MOTHER/FEMALE GUARDIAN
NAME:		
ADDRESS:		
CITY, STATE, ZIP CODE:		
HOME PHONE:		
WORK PHONE:		
CELLULAR PHONE:		
EMAIL:		
STATE JOINT OR SOLE CUSTODY, IF APPLICABLE:		

	EMERGENCY CONTACT #1	EMERGENCY CONTACT #2
NAME:		
RELATIONSHIP:		
HOME PHONE:		
WORK PHONE:		
CELLULAR PHONE		
EMAIL:		

AUTHORIZED FOR PICK UP, OTHER THAN PARENT/GUARDIAN
(at least 21 years old with ID)

	DESIGNATED ADULT #1	DESIGNATED ADULT #2
NAME:		
HOME PHONE:		
WORK PHONE:		
CELLULAR PHONE:		

YOUTH CHALLENGE ACADEMY - HILO
PT UNIFORM SIZES

CANDIDATE'S LAST NAME: _____

CANDIDATE'S FIRST NAME: _____

DATE: _____

CLASS: _____

CIRCLE THE CANDIDATE'S SIZE

T-Shirt Size (men's cut) ◯ XS ◯ S ◯ M ◯ L ◯ XL ◯ XXL ◯ XXXL

Athletic Shorts (pull on active wear - aka: "basketball shorts") ◯ XS ◯ S ◯ M ◯ L ◯ XL ◯ XXL ◯ XXXL

ADOPT A HIGHWAY

State of Hawaii Department of Transportation

Release Form for Adopt-A Highway Participants Under Age Eighteen

Date _____

I, a member of the HI National Guard Youth Challenge Academy (Adopt-A-Highway group) have attended the roadside safety training program as a prerequisite to participation in the Adopt-A-Highway Program.

I do hereby release and discharge the State of Hawaii, Department of Transportation, and their officers, agents and employees, from all claims, demands and causes of action of every kind whatsoever for any damages and, or, injuries which may result from my participation in the Adopt-A-Highway and other voluntary activities on or near the highway rights-of-way.

I further agree to hold harmless the State of Hawaii, Department of Transportation, and their officers, agents and employees, from liability for any damages or injuries resulting from any acts or failure to act on my part during my participation in said voluntary activities on or near the highway rights-of-way.

Name: _____
Print or Type Name of minor Signature

Parent or Guardian: _____
Print or Type Name Signature

Address: _____

_____

_____

(Sign and submit this form to the DOT before participation)

RELEASE OF CLAIMS

This Release of Claims is made on _____, 20_____, by _____ (Name of Participant), whose date of birth is _____, and whose address is _____ (Street Address/P. O. Box #) (Town/City) (State) (Zip Code).

In consideration of the permission granted to me by the County of Hawai'i, State of Hawai'i, to participate in Service to Community (Description of Activity) program at All Hawaii County Facilities (Name and Address of Facility) (hereafter "Facility") from _____ (Dates of Activity), 20_____, to _____, 20_____.

I hereby release the County of Hawai'i, its agents, independent contractors, and employees from all actions, causes of action, damages, claims or demands, which I, my heirs, personal representatives, or assignees may have against the County of Hawai'i, and other above-named parties for all injuries, known or unknown, which may incur by my participation in the above-described activity or by my use of the above-described Facility.

I do further agree that I shall indemnify and save harmless the County of Hawai'i, or any of its officers or employees, either jointly or severally, from any and all claims, demands, damages, loss of service, or expense for property damage and for personal injuries or actions brought by a third party resulting or arising from my participation in the above-described activity or my use of the Facility.

I, the undersigned, have read this Release and understand all of its terms. I execute it voluntarily and with full knowledge of its significance.

IN WITNESS WHEREOF, I have executed this Release at Hawaii National Guard Youth Challenge Academy, Hilo Campus (Place of Execution) on the day and year first written above.

Participant's Signature Telephone No.

If Participant is under 18 years of age:

Signature of Parent or Guardian Telephone No.

Printed Name of Witness (age 18 or older) (All signatures require a witness) Witness's Signature (All signatures require a witness signature) Telephone No.

5/21/09

Please submit the filled Release and Waiver Form in hard copy with your original signature(s) to:

Keaukaha One Youth Development
RISE 21st Century After School Program
67 Keokea Loop, Hilo, HI 96720
Ph. (808)895-8666, Email: keahi.koyd.rise@gmail.com

Assumption of Risk, Release and Waiver

I, _____(the undersigned) understand that there are risks involved in my participation in service- learning activities, projects, and programs on land as well as sea, on land administered by or through Keaukaha One Youth Development ("KOYD") or RISE 21st Century After School Program ("RISE") by the State of Hawai'i, including the Department of Transportation, and its Harbors Division, beginning on the date of my signature below and continuing until my completion of the program, including the risk of PROPERTY DAMAGE, PERSONAL INJURY, OR DEATH. I understand that KOYD, RISE, the State of Hawai'i, including the Department of Transportation, and its Harbors Division as well as their officers, agents, employees, or representatives does not provide liability insurance, or otherwise indemnify me or anyone else who may participate in these programs, projects and activities, for any injuries or any other liabilities arising from my participation, including transportation to and from the sites of service.

Therefore, in consideration of my participation, I assume all risks and responsibilities in relation to my participation in service-learning activities, projects, on land administered by or through KOYD and/or RISE, I release, agree to defend, hold harmless, and indemnify KOYD, RISE and, the State of Hawai'i, the Department of Transportation, Harbors Division and their other entities, as well as their officers, agents, employees, or representatives from and against all liabilities, claims, demands or causes of actions, including claims for property damage, personal injury, or death CAUSED BY THE PASSIVE OR ACTIVE NEGLIGENCE OF MYSELF AND/OR KOYD, RISE, THE STATE OF HAWAI'I, DEPARTMENT OF TRANSPORTATION, HARBORS DIVISION AND OTHER ENTITIES, AS WELL AS THEIR OFFICERS, AGENTS, EMPLOYEES, OR REPRESENTATIVES for any hidden, latent or obvious defect in equipment, or caused by any other activities of mine, or anyone else who may be a participant in the above-mentioned activities, including transportation to and from the sites of service.

I declare that the information provided by me is correct and made in good faith.

PHOTO/VIDEO RELEASE: I understand that my classroom and field work and photo/video likeness may be selected for use in reporting, program materials, and outreach. In this event, I will make no monetary or other claim against KOYD, RISE, the State of Hawai'i, the Department of Transportation, Division of Harbors and other entities, as well as their officers, agents, employees, or representatives for such use. Unless initialized below, I hereby

give my permission for the release of my work and likeness for program use. I do agree to and will uphold the terms of this agreement.

_____I do NOT allow my photo or video likeness used by any of the institutions or programs mentioned in this agreement. (Initial)

It is your own responsibility to make this decision known to site leaders and participants in activities, where photographing, taping, or filming may take place.

Participant signature | Date | Print name

Parent or Guardian Signature (if participant is under 18) | Date | Print Parent/Guardian Name

Participant email
Parent/Guardian Email | Phone

Address while in Hawai'i | City | State | Zip

Emergency contact: Name, relationship, and phone number

Authorized Official Signature | Date | Print name

Family Tree Project, LLP

Authorization to Release/Obtain Information

I, _____ hereby agree that the Family Tree Project, LLP,
_____ Release _____ Obtain (client/parent /legal guardian initials on line) information about me, the

consumer, to/from the following individual:

From/To: Youth Challenge Academy
1787 Shangrila St.
Kapolei, HI 96707
Phone: (808) 673-7530

The form in which this information will be shared (check appropriate): ____ Written ____Verbal ____Phone

For the person(s) providing consent
This consent has been freely, voluntarily and without coercion.
I was able to ask questions and receive answers about this release.
I hereby authorized obtaining the information as specified above and further understand that: Those who receive this information cannot disclose it to others without further consent, unless permitted by Federal or State law.

I also understand that I may revoke this consent at any time either verbally or in writing, except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows:

_____
(Specification of the date, event or condition upon which this consent expires)

Consent expires on this day (check one): ____ One year from signing _____ Other Date: _____
(Consent cannot be of greater length than one year)

_____ _____
Print name of client providing consent Date

_____ _____
Signature of client providing consent Signature of Parent or Guardian

_____ _____ _____
Signature of Staff/Agency Witness Title of Witness Date

This consent is withdrawn effective ____/____/____ Withdrawal requested: _____ Verbally _____ In Writing

Signature of Client:_____

**Original copy to Client's file (Family Tree Project)* **Copy to Provider(s)/client*

Initial Client Information

Parent Name: _____ Birth Date:_____/_____/_____

Parent Name:_____ Birth Date:_____/_____/_____

Child(ren) Names:

_____ Birth Date:_____/_____/_____

_____ Birth Date:_____/_____/_____

_____ Birth Date:_____/_____/_____

_____ Birth Date:_____/_____/_____

_____ Birth Date:_____/_____/_____

Address:_____ Phone:_____

Email:_____

Insurance Information:

Policy holder:_____ Insurance Co. _____

Insurance ID:_____ Policy holder Birthdate:_____

Has anyone in your family been in treatment before?_____

If so, who, where and when? _____

Please print legal name clearly:_____

Parent/Guardian Signature: _____

Family Tree Project, LLP

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Understanding Your Protected Health Information (PHI)
When you visit us, a record is made of your symptoms, examinations, test results, diagnoses, treatment plan, and other mental health or medical information. Your record is the physical property of the mental health care provider. The information within belongs to you. Being aware of what is in your record will help you to make more informed decisions when authorizing disclosures to others. In using and disclosing your PHI, it is our objective to follow the Privacy Standards of the Federal Health Insurance Portability and Accountability Act (HIPAA) and requirement of state law.

Your Mental Health and/or Medical Record Serves as:

- A basis for planning your care and treatment.
- A means of communication among the health professionals who may contribute to your care.
- A legal document describing the care you received.
- A means by which you or a third party payer can verify that services billed were actually provided.
- A source of information for public health officials charged with improving the health of the nation.
- A source of data for facility planning and marketing.
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Responsibilities of (Family Tree Project, LLP)
We are required to:

- Maintain the privacy of your PHI as required by law and provide you with notice of legal duties and privacy practices with respect to the PHI that we collect and maintain about you.
- Abide by the terms of this notice currently in effect. We have the right to change our notice of privacy practices and to make the new provisions effective for all protected health information that we maintain, including that obtained prior to the change. Should our information practices change, we will post new changes in the reception room and provide you with a copy.
- Notify you if we are unable to agree to a requested restriction.
- Use or disclose your health information only with your authorization except as described in this notice.

Family Tree Project, LLP

Your Protected Health Information (PHI) Rights
You have the right to

- Review and obtain a paper copy of the notice of information practices and your health information upon request. A few exceptions apply. Copy charges may apply.
- Request and provide written authorization and permission to release PHI for purposes of outside treatment and health care. This authorization excludes psychotherapy notes and any audio/video tapes that may have been made with your permission for training purposes.
- Revoke your authorization in writing at any time to use, disclose, or restrict health information except to the extent that action has already been taken.
- Request a restriction on certain uses and disclosures of PHI, but we are not required to agree to the restriction request. You should address your restriction in writing to the Privacy Officer by asking for the name of Privacy Officer, address, and phone. We will notify you within 10 days if we cannot agree to the restriction.
- Request that we amend your health information by submitting a written request with reasons supporting the request to the Privacy Officer. We are not required to agree with the requested amendment.
- Obtain an accounting of disclosures of your health information for purposes other than treatment, payment, health care operations, and certain other activities for the past six years but not before April 14, 2003.
- Request confidential communications of your health information by alternative means or at alternative locations.

Disclosures for Treatment, Payment, and Health Operations
Family Tree Project, LLP will use your PHI, with your consent, in the following circumstances:

Treatment: Information obtained by a nurse, physician, psychologist/counselor, dentist, or other member of your health care team will be recorded in your record and used to determine the management and coordination of treatment that will be provided for you.

Disclosure to others outside the agency: If you give us written authorization, you may revoke it in writing at any time but that revocation will not affect any use or disclosures permitted by your authorization while it was in effect. We will not use or disclose your health information without your authorization, except to report a serious threat to the health or safety of a child and/or vulnerable adult.

For payment, if applicable: we may send a bill to you or to your insurance carrier. The information on or accompanying the bill may include information that identities you, as well as your diagnosis to obtain reimbursement for your health care or to determine eligibility or coverage.

For health care operations: Members of the mental health staff or members of the quality improvement team may use the information in your health record to assess the performance and operations of our services. This information will be used in an effort to continually improve the quality and effectiveness of the mental health care and services we provide.

We may use or disclose your PHI in the following situations without your authorization: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse/neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners and organ donation, research, or workers' compensation. Under the law, we must make disclosures to you when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements.

For More Information or to Report a Problem

If you have questions and would like additional information, please ask your clinician. He/she will provide you with additional information or put you in contact with the designated Privacy Officer. If you are concerned that your privacy rights have been violated or you disagree with a decision we have made about access to your health information, you may contact the Privacy Officer. We respect your right to privacy of your health information. There will be no retaliation in any way for filing a complaint with the Privacy Officer of our agency or the U.S. Department of Health and Human Services.

Family Tree Project, LLP

HIPAA Privacy Authorization for Use and Disclosure of Personal Health Information

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations as amended from time to time.

You may refuse to sign this authorization.

By my signature below, I acknowledge that I have received and read the Notice of Health Information Privacy Practices. I have been provided a copy of, read and understand (Family Tree Project) HIPAA Privacy Notice containing a complete description of my rights, and the permitted uses and disclosures of my protected health information under HIPAA. Further, I acknowledge that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and is no longer protected under HIPAA.

Name _____
Last First MI

Address: _____
Street City State Zip

Date of Birth:_____

Client Signature: _____ Today's Date:_____

Parent/Guardian Signature (if client under 18)_____

For office use only

I attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained.

Reason: _____

_____ _____
Clinician Signature Date

Individual HIPAA Provider Number of Clinician Completing Form: _____

HIPAA Organization Number of Clinician Completing Form: _____

Family Tree Project, LLP

Consent for Evaluation and/or Treatment

Child Form

Name:

Date of Birth:

1. **Consent to Evaluate/Treat:** I voluntarily consent that my child will participate in a mental health evaluation and/or treatment by staff from Family Tree Project, LLP. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services
    c. The manner in which treatment will be administered

    The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Hawaii State Law for Mental Health Counseling. In addition to following the Hawaii Administrative Code, Family Tree Project, LLP, also follows ethics and requirements regulated by the American Counseling Association and the National Board of Certified Counselors.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered through psychological interviews, psychological assessment or testing, and psychotherapy, as well as expectations regarding the length and frequency of treatment. It may be beneficial to my child, as well as the referring professional, to understand the nature and cause of any difficulties affecting my child's daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

3. **Charges when Applicable*:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. If fees are applicable, I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees, **when applicable will be agreed upon prior to the service with the responsible party**. Clients have a right to terminate treatment at any time.

4. **Confidentiality, Harm, and Inquiry:** Information from my child's evaluation and/or treatment is contained in a confidential medical record at Family Tree Project, LLP. I consent to disclosure for use by Family Tree Project, LLP, staff for the purpose of continuity of my child's care. Per Hawaii State law, information provided will be kept confidential with the following exceptions: 1) if my child is deemed to present a danger to himself/herself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

5. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment of my child at any time by providing a written request to the treating clinician.

6. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

_____ _____

Signature of legal guardian for minor under age 18 **Date**

_____ _____

Signature of witness **Date**

Note: Hawaii State Law (HRS 577-26e) allows minors of any age who profess to seek treatment for Drug and/or Alcohol abuse without parental consent.

Revised 11/14

HAWAII NATIONAL GUARD YOUTH CHALLENGE ACADEMY - MEDICAL AID STATION INFORMATION

The Youth Challenge Academy Medical Aid Station (MAS) addresses and or assists daily with medical issues, which include:

- Conducting sick call twice daily and providing medical care to youth as needed.
- Responding in an on-call basis to deal with after hours, non-emergency medical issues.
- Overnight medical facilities are available in the Medical Aid Station, if needed.
    - Emergency situations are handled with support of the MAS staff and Emergency 911, as required.
- Coordinating cadets' off campus/out-of-town medical, dental, and/or counseling appointments.
- Maintaining and distributing prescription medications for cadets as prescribed by physicians.
- Coordinating with local medical/mental health care facilities to provide expedited services for cadets and assist with documentation required for insurance processing.
- Reviewing and maintaining copies of all cadet physical examination reports and immunization records as follows:
    - **All cadets are required to have an annual physical examination or sports physical on file in the MAS**.
- No cadet is admitted to the Academy until their physical examination is current and legible copies provided to the MAS.
    - Hawaii State Law, Hawaii Administrative Rules Title 11, and Department of Health, Chapter 157 requires all students to be immunized against the following illnesses:
        - Polio
        - Diphtheria
        - Tetanus
        - Mumps
        - Rubella (German measles)
        - Rubella (measles)
        - Pertussis
        - Hepatitis

Note: Hawaii Law requires the MAS to file reports on the status of immunizations with the Hawaii Department of Health. There may be medical fees, not limited to, but including Office Fees, Physician's fees, etc.

Health, Medical, or Accident Insurance Requirement - I understand that medical insurance is required to participate in the Hawaii National Guard Youth Challenge (YCA) program. A copy of the **front and back** of each cadet or guardian's insurance card is required as evidence of insurance and will be kept on file in the MAS, Admissions Office and Charge of Quarters. If there is any change in medical insurance coverage for a cadet, the responsible party must notify YCA within 5 business days of the change.

YCA will not accept financial responsibility for injuries to a cadet regardless of cause. ***The cadet, parent, guardian or previously established responsible party is required to pay the physician, hospital or any other medical bills directly to the billing agency*.**

There is no charge for consultation and treatment by the MAS Staff.

Parent/Guardian Initials _____ /_____ Cadet Initials _____

NOTE: Cadets who are part of an HMO plan, or who have a previously established primary care physician will be seen by said agency for all non-emergency situations if at all possible. If a cadet is seen by a physician contracted through the MAS, clinic, or hospital there may be a charge for their services, which will be billed to the responsible party. The parent or guardian is responsible for coordinating necessary medical referral services while cadets are attending YCA

HAWAII NATIONAL GUARD YOUTH CHALLENGE ACADEMY
MEDICAL AID STATION
Medical Treatment Authorization & Release of Information

FULL NAME of CADET: _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____ **DATE OF BIRTH**: _____ / _____ /_____

By my initials below, I hereby grant permission for my cadet to receive emergency medical treatment, non-emergency medical treatment, behavioral/mental health care and/or routine health care as deemed necessary by the MAS staff while enrolled as a cadet at YCA. Consent is granted for the MAS staff of YCA to act in my stead to select attending physicians, specialists, surgeons, psychiatrists, therapists, dentists, and medical facilities as necessary. I understand that I am financially responsible for services provided to my cadet and may receive a statement/bill from the above noted professionals or medical facilities. Consent is also given for all medical and mental health records to be released to the YCA medical staff upon request, along with the release of information concerning my cadet, to health care and/or mental health professionals as deemed necessary by the YCA medical staff.

This authorization will remain in effect during my Cadet's enrollment at Hawaii Youth Challenge Academy or until revoked by me in writing and that statement is received by the MAS staff.

Parent/Guardian Signature: _____ Parent/Guardian Initials _____ /_____ Cadet Initials _____

Privacy Policies – By my initials below, I understand that the cadet health record is kept on file in the MAS and contains their symptoms, examination/test results, diagnoses and treatment, a plan for future care or treatment and billing related information.

MAS Responsibilities:

- The MAS is required by law to maintain the privacy of a cadet's health information and to provide the patient and the parent/guardian a description of our privacy practices.
- The MAS may disclose health information about a cadet to doctors, nurses, technicians, or other medical personnel involved in taking care of the cadet. Examples would include, but are not limited to lab work, meals, x-rays, etc.
- The MAS may use and disclose health information about a cadet's treatment for physicians to bill and collect payment from insurance providers or third-party payers.

Example:

1. Giving the insurance company information about a cadet's x-rays for payment or reimbursement of charges.
2. Telling your health plan provider about treatment your cadet needs to determine whether your plan allows for coverage of such treatment; such as MRIs, physical therapy, etc.Members of the staff may use information in a cadet's health record to assess required care and outcomes in the youth's individual case. Results may also be used to evaluate service needs or treatment plans to improve the quality of care for all cadets that we serve. **Parent/Guardian Initials _____ /_____ Cadet Initials _____**

HAWAII NATIONAL GUARD YOUTH CHALLENGE ACADEMY
MEDICAL AID STATION
Policies & Cadet Physical Aptitude

Privacy Policies – You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your cadet's care. In some circumstances, we may deny your request to inspect and/or copy a cadet's records in accordance with The Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you are denied access, you may request that the denial be reviewed. If you feel the health information about your cadet is incorrect or incomplete, you may request to have that information amended. You have a right to request an amendment for as long as the information is kept by or for the MAS.

You have a right to request a restriction or limitation on the health information we use or disclose about your cadet. We are not required to comply with your request, however, we do our best to uphold your desires unless release of the medical record information is determined to be necessary for the treatment of your cadet.

We may also use and disclose health information for the following types of entities including, but not limited to:

- Public Health or Legal Authorities charged with preventing or controlling disease, injury, etc.
- Military Command Authorities
- Health Oversight Agencies
- National Security and Intelligence Agencies
- Protective Services for the President and others

We reserve the right to change or revise this notice as needed. The change or revision to this notice will be effective for information we already have about your cadet, as well as any information we receive in the future. The most current notice will be posted in the MAS and will include the effective date.

Parent/Guardian Initials _____ Cadet Initials _____

Physical Aptitude – To the best of my knowledge, my cadet is in good physical condition and participation in the program will not have an adverse effect on his/her health and well-being*.

[ ] YES

[ ] NO Please specify:_____

Has your cadet been diagnosed with any mental illness to include, but not limited to, anxiety, depressions, ADD, or ADHD?*

[ ] NO

[ ] YES Please Specify:_____

Please list all medications your cadet is currently taking on a regular basis including medications for mental illness*:

_____

_____

Please list anything (medications, foods, latex, etc.) to which your cadet may be allergic*:_____

_____

** You must inform YCA of any changes in physical condition or status of general health and fitness.*

Parent/Guardian Initials _____ /_____ Cadet Initials _____

HAWAII NATIONAL GUARD YOUTH CHALLENGE ACADEMY
MEDICAL AID STATION
Responsible Party Payment Information
ALL INFORMATION ON THIS PAGE MUST BE COMPLETED!!!!

PARENT/GUARDIAN/RESPONSIBLE PARTY INFORMATION:

(Note: Responsible Party will be billed if insurance does not pay).

Name of Father/Guardian: _____

Address:

_____

Home Telephone #: (____) _____ - _____ Office #: (____) _____ - _____ Cell #: (____) _____ - _____

Name of Mother/Guardian: _____

Address:

_____

_

Home Telephone #: (____) _____ - _____ Office #: (____) _____ - _____ Cell #: (____) _____ - _____

RESPONSIBLE PARTY IS: (Circle one) FATHER MOTHER GUARDIAN OTHER

MEDICAL INSURANCE INFORMATION: Please complete the following information pertaining to the individual whose name appears on the insurance card AND provide a copy of the FRONT *and* BACK of the INSURANCE CARD.

Adult Carrying Insurance: _____ Relationship to Cadet: _____

Adult's Date of Birth: _____ / _____ / _____ Adult's Social Security #: _____ - _____ - _____

Adult's Employer: _____ Employer's Telephone #: (____) _____ - _____

Employer's Address: _____

Name of Insurance Company: _____ Telephone #: (____) _____ - _____

Address: _____ City: _____ State: Zip code: _____

Policy #: _____ Certificate #: _____ Group #: _____

_____ _____

CANDIDATE SIGNATURE **DATE**

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

HAWAII NATIONAL GUARD
YOUTH CHALLENGE ACADEMY

P.O. Box 5210 Hilo, HI 96720
Ph: (808) 430-4184 fax: (808) 933-1403

CONSENT TO ADMINISTER MEDICATION

I affirm I am the parent and/or legal guardian of_____
(Name of Minor)

DOB of Minor: _____

As the parent and/or legal guardian, I hereby authorize HINGYCA—Medical Department, and/or its agents to administer medication including over the counter (OTC) medication as well as medication prescribed by his/her Physician to my son/daughter.

_____
(Name of Minor)

I hereby consent and authorize the administration of OTC medication that may be considered advisable or necessary, in the opinion of the HINHYCA—Medical Department to my son/daughter.

_____
(Name of Minor)

I affirm that I have read and understand the **Consent to Administer Medication Form**.

Parent/Guardian Name (print): _____

Parent/Guardian Signature: _____

Date: _____ Primary Phone: _____

HAWAII NATIONAL GUARD
YOUTH CHALLENGE ACADEMY

P.O. Box 5120 Hilo, HI 96720
Ph: (808) 430-4184 fax: (808) 933-1403

Doctor

IMMUNIZATION RECORD/TB CLEARENCE

Name _____
(Last) (First) (Middle Initial)

☐ Female Birthdate _____ /_____ / _____
☐ Male

Parent's Name _____ _____
(Mother/Guardian) (Father/Guardian)

IMMUNIZATIONS (VACCINES, DATES GIVEN: MONTH/DAY/YEAR)									
DTaP, DTP, DT, or Td		Pollo (IPV or OPV)		HIB *Haemphilus Influnxae* type B		Hepatitis B	Varicella	MMR	
Type	Date	Type	Date	Type	Date	Date	Date	Date	Check if done
									☐ DTaP
									☐ Polio
									☐ HIB
									☐ HEP
								Measles	☐ MMR
			OTHER						☐ Varic
			Date		Date		Date	Mumps	
								Rubella	

TUBERCOLOSIS EXAMINATION MANTOUX TEST (INTRADERMAL)			
Date Given	Date Read	Results (mm)	Physician, APRN, PA or Clinic

CHEST X-RAY			
Date	Results	Location	Physician, APRN, PA or Clinic

Physician, APRN, PA or Clinic
_____
(Signature or stamp if different from above)

Vision: _____ / _____

Glasses: _____

Comments:

Hawaii State Department of Education
PHYSICAL EXAMINATION FOR ATHLETES

Student's Name _____ M/F _____ Date of Birth ____ / ____ / _____ Grade _____
(Print) Last First MI Month Day Year

Address _____ Home Phone _____ Student Resides With _____
Street No. City State Zip Code

Fall Sport _____ Winter Sport _____ Spring Sport _____

Father/Legal Guardian's Name _____ Bus. Phone _____ Cellular Phone _____

Mother/Legal Guardian's Name _____ Bus. Phone _____ Cellular Phone _____

Emergency Contact _____ Bus. Phone _____ Cellular Phone _____
Name & Relationship

Emergency Contact _____ Bus. Phone _____ Cellular Phone _____
Name & Relationship

Emergency Contact _____ Bus. Phone _____ Cellular Phone _____
Name & Relationship

Health and/or Insurance Carrier _____ Policy # _____

The student and parent/legal guardian consent and authorize school officials through an Athletic Health Care Trainer (AHCT), qualified coach/staff, or physician as determined by the school, to provide any first aid and/or emergency care as well as follow-up first aid or medical treatment that may be reasonably necessary for the student as determined by a school official in the course of athletic practice, competition or travel.

The student and parent/legal guardian further consent and authorize the school's AHCT to provide appropriate therapeutic modalities in order to return the student to athletic competition, such care to be conducted under the direction of a physician.

The student and parent/legal guardian further consent and authorize the school's AHCT to administer baseline and/or post injury concussion management assessment in order to manage a concussion or suspected head trauma, such care to be conducted under the direction of a physician.

The student and parent/legal guardian hereby consent to the release of medical information by the physician to the school to obtain information regarding the medical history, records of injury or surgery, serious illness, and rehabilitation results of the student from his/her physician(s). We understand that the purpose of this request for medical information is to assist the school in the management or rehabilitation of an injury/illness. This information is confidential and except as provided in this release will not be otherwise released by the parties in charge of the information. This release remains valid until revoked by the adult student or parent/legal guardian in writing.

Student's Signature _____ Parent/Legal Guardian's Signature _____ Date _____

(Parent/Legal Guardian: Please Fill Out the Back Side of this Form)

To Be Completed By Physician Only

Height _____ feet & inches Weight _____ lbs Blood Pressure _____ / _____ Pulse _____ bpm

Vision: R 20/ _____ L 20/ _____ Corrected: Yes No Pupils: Equal _____ Unequal _____

Asthma _____ (Medication Used) Diabetes _____ (Medication Used) Allergies _____ (Medication Used)

MEDICAL	NORMAL	COMMENTS	INITIALS
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph nodes			
Heart/Murmurs			
Pulses			
Lungs			
Abdomen			
Skin			
Genitalia			
MUSCULOSKELETAL			
Neck			
Back/Spine			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Calf/Ankle			
Foot/Toes			
Other			

(Over)

Parent/Legal Guardian and Student to fill out BEFORE Physical Examination

Explain "Yes" answers below. Circle questions you don't know the answer to.

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	❑	❑
2. Do you have an ongoing medical condition (like diabetes or asthma)?	❑	❑
3. Are you currently taking any prescription or nonprescription (over the counter) medicines or pills?	❑	❑
4. Do you have allergies to medicines, pollens, foods or stinging insects?	❑	❑
5. Have you ever passed out or nearly passed out DURING exercise?	❑	❑
6. Have you ever passed out or nearly passed out AFTER exercise?	❑	❑
7. Have you ever had discomfort, pain or pressure in your chest during exercise?	❑	❑
8. Does your heart race or skip beats during exercise?	❑	❑
9. Has a doctor ever told you that you have: (check ALL that apply) ❑ High blood pressure ❑ A heart murmur ❑ High Cholesterol ❑ A heart infection		
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echochardiogram)	❑	❑
11. Has anyone in your family died for no apparent reason?	❑	❑
12. Does anyone in your family have a heart problem?	❑	❑
13. Has any family member or relative died of heart problems or of sudden death before age 50?	❑	❑
14. Has a family member died while exercising?	❑	❑
15. Does anyone in your family have Marfan Syndrome?	❑	❑
16. Have you ever spent the night in a hospital?	❑	❑
17. Have you ever had surgery?	❑	❑
18. Have you ever had an injury, like sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, list affected area: _____	❑	❑
19. Have you had any broken or fractured bones or dislocated joints? If yes, list affected area: _____	❑	❑
20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, list affected area: _____	❑	❑
21. Have you ever had a stress fracture?	❑	❑
22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	❑	❑
23. Do you regularly use a brace or assistive device?	❑	❑
24. Has a doctor ever told you that you have asthma or wheezing?	❑	❑

	Yes	No
25. Do you cough, wheeze or have difficulty during or after exercise?	❑	❑
26. Have you ever used an inhaler or taken asthma medicine?	❑	❑
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	❑	❑
28. Have you had infectious mononucleosis (mono) within the last month?	❑	❑
29. Do you have any rashes, pressure sores, or other skin problems?	❑	❑
30. Have you ever had a herpes skin infection?	❑	❑
31. Have you ever had a head injury or concussion?	❑	❑
32. Have you been hit in the head and been confused or lost your memory?	❑	❑
33. Have you ever had a seizure?	❑	❑
34. Do you have headaches with exercise?	❑	❑
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	❑	❑
36. Have you ever been unable to move your arms or legs after being hit or falling?	❑	❑
37. When exercising in the heat, do you have severe muscle cramps, or become ill?	❑	❑
38. Do you have any hearing problems?	❑	❑
39. Do you have a hearing device?	❑	❑
40. Do you have a family member with hearing problems?	❑	❑
41. Has a doctor told you that you, or does someone in your family have sickle cell trait or sickle cell disease?	❑	❑
42. Have you had any problems with your eyes or vision?	❑	❑
43. Do you wear glasses or contact lenses?	❑	❑
44. Do you wear protective eyewear, such as goggles or a face shield?	❑	❑
45. Are you happy with your weight?	❑	❑
46. Would you like to lose weight?	❑	❑
47. Would you like to gain weight?	❑	❑
48. Has anyone recommended you change your weight or eating habits?	❑	❑
49. Do you limit or carefully control what you eat?	❑	❑
50. Do you have any concerns that you would like to discuss with a doctor?	❑	❑
51. Do you feel depressed?	❑	❑
52. Do you have a history of multiple or long nosebleeds?	❑	❑
53. **MALES ONLY:** Do you ever have or had swelling of your testicles or groin?	❑	❑
FEMALES ONLY		
54. Have you ever had a menstrual period?	❑	❑
55. How many periods have you had in the last 12 months? _____		

EXPLAIN "YES" answers here: (Add additional pages if necessary)

_____

_____

_____

I hereby verify to the best of my knowledge that the answers which have been provided to the above questions are correct.

Student's Signature _____ Parent/Legal Guardian's Signature _____ Date _____

Clearance: (Place a check in appropriate box below)

❑ Cleared for **all** sports

❑ Cleared **after** completing evaluation/rehabilitation for _____

❑ **Not** cleared for: ❑ Collision (Football)

❑ Contact (Baseball, Basketball, Cheerleading, Judo, Softball, Soccer, Volleyball, Wrestling)

❑ Non contact ❑ Strenuous ❑ Moderately Strenuous ❑ Non-strenuous

Reason not cleared _____

Physician's Recommendation _____ Date of Physical Exam _____

Physician's Name _____ Telephone _____

Address _____ Fax Number _____

Physician's Signature _____

Hawaii National Guard Youth Challenge Academy
HILO CAMPUS
PO Box 5210, Hilo, HI 96720
Phone: (808) 430-4184 Fax (808) 933-1403

Dentist

This certificate is not valid unless all fields are complete

Information (Please print)

Last Name:	**First Name:**	**Birthdate (MM/DD/YYYY)**
Parent or Guardian Name:	**Telephone (Home or Mobile)**	
Street Address:	**City and State**	
Name of High School currently attending:	**Grade:**	**Gender: ( ) Male ( ) Female**

Date of Dental Screening: _____

Treatment Needs (check ONE only based on screening results, prior to treatment services provided):

( ) NO Obvious Problems – youth's hard and soft tissues appear visually healthy and there is no apparent reason for the child to be seen before the next routine dental checkup.

( ) REQUIRES Dental Care – tooth decay or a white spot lesion is suspected in one or more teeth, or gum infection is suspected.

( ) URGENT Dental Care – obvious tooth decay is present in one or more teeth, there is evidence of injury or severe infection, or the child is experiencing pain.

Tooth decay: visible decay cavity or hole in a tooth with brown or black coloration, or a retained root.
White spot lesion: a demineralized area of a tooth, usually appearing as a chalky, white spot or white line near the gum line. It is considered as early indicator of tooth decay, especially in primary (baby) teeth.
Gum infection: Gum (gingival) tissue is red, bleeding, or swollen.

SCREENING PROVIDER (Check ONE only):

( ) DDS/DMD ( ) RDH ( ) MD/DO ( ) PA ( ) RN/ARNP

Provider Name: (please print) _____ Provider Business Phone: _____

Provider Business Address: _____

Signature and Credential of Provider or Recorder: _____

Date Signed: _____

***Recorder: An authorized provider (DDS/DMD, RDH, MD/DO, PA, RN/ARNP) may transfer information onto this form from another health document. The other health document should be attached to this form.**

Hawaii National Guard Youth Challenge Academy
JUVENILE CRIMINAL RECORD AND E-CRIM REQUEST

All 16 and 17-year-old applicants are required to provide a juvenile criminal record as part of the application process. **(Applicants that are 18 years old are to follow the directions at the bottom of this page).** Those without prior arrests or with a status offence (i.e. runaway, curfew, truancy) are to make a request in person, with a parent or legal guardian at your Family Court. These are no fee. ID must be provided, and you may be asked to provide an original birth certificate and social security card for the youth applicant.

OAHU – First Circuit
Kapolei Judiciary Complex (Courthouse)
4675 Kapolei Parkway – Juvenile Special Services (2nd floor)
Counter hours: 8:00am to 4:30pm Monday-Friday, except state holidays
Phone Contact: (808) 954-8000

MAUI – Second Circuit
Hoapili Hale (Wailuku Courthouse)
2145 Main Street – Juvenile Client and Family Services Branch (2nd floor)
Counter hours: 8:00am to 4:30pm Monday-Friday, except state holidays
Phone Contact: (808) 244-2770

LANA'I – District Court (808) 565-6447
MOLOKA'I – District Court (808) 553-1100

KAUA'I – Fifth Circuit
Pu'uhonua Kaulike Building (Lihue Courthouse)
3970 Ka'ana Street – Juvenile Client and Probation Services
Counter hours: 8:00am to 4:30pm Monday-Friday, except state holidays
Phone Contact: (808) 482-2350

HAWAI'I – Third Circuit
Hale Kaulike (Hilo Courthouse)
777 Kilauea Avenue #A01 – Juvenile Client Service Branch
Counter hours: 8:00am to 4:30pm Monday-Friday, except state holidays
Phone Contact: (808) 961-7500

HAWAI'I – Third Circuit
Kona Courthouse
77-6399 Nalani Street #2C
Counter hours: 8:00am to 4:30pm Monday-Friday, except state holidays
Phone Contact: (808) 443-2112

For those that have a Probation Officer (PO), please as your PO to provide a record listing to include information about any pending and upcoming mandatory court dates. They are also welcomed to provide a recommendation letter at your request.

All 18 year old applicants are required to provide an E-Crim Record printout as a part of the application process. Place your online request at *https://ecrim.ehawaii.gov/ahewa* First: Sign In, and then be ready to provide date of birth and social security number. There is a $5.00 search fee and a $10.00 E-Crim report fee. Please submit your printed copy.

HAWAII NATIONAL GUARD YOUTH CHALLENGE ACADEMY

Hilo Campus
P.O. Box 5210
Hilo, HI 96720
Ph: (808) 430-4184 Fax: (808) 933-1403

TRANSCRIPT REQUEST FORM

***INSTRUCTIONS*:**

Applicant/Parent/Legal Guardian:

1) Fill in all information completely and clearly in black or blue ink.
2) Please ensure that this form is signed by both applicant and parent/legal guardian.
3) Submit this form to your high school by mail or in person. DO NOT MAIL THIS FORM TO US AS IT WILL NOT BE FORWARDED TO YOUR SCHOOL.

(NOTE: If you have any outstanding debts with your high school, they may require that you pay these debts before releasing your transcript to us. The Hawaii National Guard Youth Challenge Academy will not be involved in the collection of these debts but, we are requiring that your transcript be received prior to your interview date.)

Registrar:

1) Please provide us an "unofficial copy" of the applicant's academic record to include the following:
   a) Transcript of course work through last marking/grading period.
2) Please mail transcripts to us at: Hawaii National Guard
   Youth Challenge Academy
   Admissions
   P.O. Box 5210
   Hilo, HI 96720
3) Or fax to us at (808) 933-1403 Attn: Outreach Dept.

Applicant Information			
Last Name	First Name		Middle
Address		City	State	Zip Code
Date of Birth	Age	Gender – Circle one	Social Security Number
/ /		Male Female	- -
Name of last high school attended	Address of high school		
Applicant Signature	Parent/Legal Guardian Signature		

DO NOT SUBMIT THIS FORM TO YOUTH CHALLENGE!
YOU MUST SUBMIT IT TO YOUR HIGH SCHOOL

HAWAII NATIONAL GUARD
YOUTH CHALLENGE ACADEMY – HILO CAMPUS

Mandatory Packing List (Revised January 2023)

"If it's not on the list, it's NOT allowed"

To be worn on In Processing Day:

- ☐ White t-shirt, black shorts, white mid-calf socks, and black running shoes

To be hand-carried:

- ☐ Government issued ID
- ☐ Any original enrollment paperwork due to the Outreach Office

To be packed: (Mark all hygiene products with candidates LAST NAME ONLY)

- ☐ 5 plain white t-shirts (No "V" neck styles)
- ☐ 5 pairs of black athletic shorts (sewn pockets)
- ☐ 5 pairs of spandex shorts (black or gray)
- ☐ 10 pairs of cotton underwear (solid colors only)
  - Males – long briefs, NO boxers
  - Females – NO lingerie, thong, bright, or pattern styles
- ☐ 10 pairs of white mid-calf socks ONLY
- ☐ 1 plain set of sweatshirt and sweatpants (black or gray, NO hoods, pockets, or zippers)
- ☐ 1 extra pair of black running shoes
- ☐ 1 black shoe polish (NO liquid)
- ☐ 1 pair of rubber shower slippers/slides (black, NO crocs)
- ☐ 2 bath towels
- ☐ 2 washcloths
- ☐ Toothbrush
- ☐ Toothbrush holder
- ☐ 2 tubes of toothpaste
- ☐ 12 pack of bath bar soap (NO gel body wash)
- ☐ Plastic bar soap holder
- ☐ 2 tubes lip balm (NON flavored)
- ☐ 2 sticks of deodorant (NON aerosol)
- ☐ Address book with mentor, family, friend information (NO spiral)
- ☐ 1 box of envelopes
- ☐ 1 book of first class stamps
- ☐ 4 pencils, #2 (NO mechanical)
- ☐ Lined letter writing paper
- ☐ 2 standard dial combination padlocks
- ☐ 1 USB drive
- ☐ 5 cloth face masks (Optional)
- ☐ Prescription eyeglasses if needed (NO contact lenses)
- ☐ 1 month supply of NON scented sunscreen (To be given to the Nurse)

Additional FEMALE required items:

- ☐ 5 sports bras (white, black, or gray)
- ☐ 2 bottles of lice shampoo/treatment (To be given to the Nurse)
- ☐ Hair gel (NON alcohol, NON scented)
- ☐ 1 hairbrush or comb
- ☐ 2 large bottles of shampoo & conditioner
- ☐ 4 packs of hair bands (color matched to hair)
- ☐ 1 bottle of scalp oil (for textured hair)
- ☐ 1 large box of pads and/or tampons
- ☐ 1 loose rash guard

Recommended by not mandatory:

- ☐ 1 bottle medicated face cream
- ☐ 1 bottle unscented body lotion
- ☐ 1 bottle medicated foot powder
- ☐ Gel insoles for boots
- ☐ 1 spiritual or motivational book
- ☐ MAXIMUM of 5 personal photos 3x5 (NO tobacco, alcohol, nudity, or gang signs)
- ☐ 1 box of 500 q-tips
- ☐ 2 pump bottles of hand soap

NO ALCOHOL BASED PRODUCTS, NOARESOL PRODUCTS.
ALL CONTRABAND ITEMS WILL BE RETURNED TO PARENTS/GUARDIANS IMMEDIATELY

Bring only the items on the packing list

- No jewelry, cell phones, or other electronic devices.
- No money.
- Remove all body piercings before arriving.
- Bring all your items in a large sturdy plastic hefty bag.
    - No suitcases, duffel bags, purses, or wallets.
    - Neighbor island applicants may bring one suitcase.

Clothing/shopping tips:

- New clothing items are not necessary, do not buy expensive clothing.
- Shirts and socks are to have no name brand logo showing on the outside of clothing.
- Small logos and running shoesand shorts are allowed.
- Shorts are to be middle or lower thigh in length.
- No short shorts or shorts below the knees are allowed. Overly baggy or tight clothing is not permitted.

Female hair style:

- Have hair up in a bun or short enough so that it does not pass your shoulders.
- Hair must be all one natural color.
- No extensions or beads are allowed.

Medications:

- If you are taking any medications do not stop taking anything before arriving.
- All medications will be checked and signed in at the medical aid station.
- Bring all your medications with you in the original prescription bottle with YOUR NAME ON IT.

NO ALCOHOL BASED PRODUCTS, NOARESOL PRODUCTS.
ALL CONTRABAND ITEMS WILL BE RETURNED TO PARENTS/GUARDIANS IMMEDIATELY

HAWAII NATIONAL GUARD
YOUTH CHALLENGE ACADEMY
P.O. BOX 5210
HILO, HI 96720
(808) 369-0955/ FAX (808) 933-1403
CELL: (808) 896-8228

MENTOR APPLICATION PACKET

Aloha Mentor Prospect,

Thank you for considering to be a mentor for a Hawaii National Guard Youth Challenge Academy applicant. Your involvement during this life changing journey will play a significant part of their future. The mentoring commitment is 14 months long and starts after the Mentor Match Ceremony (see list of events below).

To be eligible for graduation from our academy, each student is REQUIRED to have a trained mentor. Please ensure you meet the following criteria:

- Be at least 23 years old.
- Be the same gender as the student.
- Clear of criminal felony convictions, alcohol or substance abuse & DUI's within the past 5 years.
- NOT living in the same household, however must live within reasonable geographic proximity from cadet.
- NOT be an immediate family member (mother, father, step-parents, siblings, step/half siblings, foster parent, legal guardian, ChalleNGe staff member, their spouses or significant other).

After the completed application is received and screened, the following event will take place:

1. You will be contacted for a telephone interview
2. Scheduled for the Mandatory Training Workshop
3. Invited to the Mentor Match Ceremony
4. Contact your student (cadet) weekly

For more information, please contact the Mentor Coordinator's office at (808)369-0955/54, or email at: stacy.j.atiz@hawaii.gov

APPLICANT YOU WILL MENTOR: _____			
YOUR RELATIONSHIP TO THE STUDENT APPLICANT: _____			
LAST NAME:		FIRST NAME:	
GENDER:	MALE / FEMALE	MARITAL STATUS:	MARRIED/ SINGLE
BIRTHDATE:		AGE:	
PHYSICAL ADDRESS:	_____ _____	MAILING ADDRESS:	_____ _____
CITY/ STATE		CITY/ STATE	
ZIP CODE		ZIP CODE	
EMAIL			
HOME PHONE	( )	BEST TIME TO CALL:	
CELL PHONE	( )	BEST TIME TO CALL:	
EMPLOYER		PHONE	( )
OCCUPATION		FULL TIME/ PART TIME	
AUTO INSURANCE	YES NO	NAME OF COMPANY	
SPECIAL INTERESTS			

Are you the parent of a HINGYCA current **applicant**?	YES NO	If yes, who:
Are you the parent of a HINGYCA **graduate?**	YES NO	If yes, who:
		Class: _____

Have you ever been a mentor for HINGYCA?	YES NO	If yes, who:
		Class: _____
		When were you trained:

References:

Name:		Relationship:	
Cell Phone:		Home Phone:	

Name:		Relationship:	
Cell Phone:		Home Phone:	

Signature: _____ Date: _____

MENTOR PROGRAM EXPLANATION &

Statement of Understanding

The Hawaii National Guard Youth Challenge Academy (HINGYCA) is a great opportunity for the youth of Hawaii ages 16-18 who are struggling in school or who have already dropped out. It is truly a "second chance" to turn their lives around. The mentoring program is a very important part of this second chance. When a teen (cadet) has a mentor, who is committed to help him/her succeed, he or she is much more likely to finish the program and return to his/ her community as a productive citizen. We all know that time is precious, however this opportunity will be ***life changing***…for the both of you.

Here is a brief description of what is involved in the MENTOR PROGRAM:

- Each applicant (student) must provide at least one COMPLETED Mentor Prospect Application.
- Prospective Mentors are screened and interviewed by the HINGYCA staff.
- Selected Mentors will receive instructions to complete the MANDATORY mentor training.
- Trained Mentors are invited to attend the Mentor Match Ceremony.
    - Matched Mentors will be committed to the 14-month mentoring period. The formal mentoring relationship begins during the 14th week of the residential phase of the program.
        - Matched Mentors are required to make weekly contact (days and times will be discussed at the Mentor Match Event).
        - Matched Mentors will be able to visit onsite (days and times will be discussed at the Mentor Match Event).
        - Matched Mentors assist with the development of the Post Residential Action Plan (PRAP).
        - Matched Mentors are invited to attend activities at HINGYCA through the Mentor Department; including FAMILY DAY and GRADUATION.
- During the POST RESIDENTIAL PHASE (from the day of graduation), mentors and graduates are required to continue weekly contacts (at least two will need to be face to face).
    - Mentors are asked to submit monthly reports with regards to graduate placement success. You will be advised during your training session of the methods of reporting as well as the deadlines that need to be met.
    - The PRAP will be utilized in this phase as a guide for success.

I HAVE READ THE ABOVE DESCRIPTION OF THE HAWAII NATIONAL GUARD YOUTH CHALLENGE MENTORING PROGRAM. I AM AWARE OF AND AGREE TO WHAT IS REQUIRED OF ME AS A MENTOR.

Print: _____

Signature: _____ Date: _____

MENTOR LIABILITY RELEASE

I understand and agree that I will be the one spending time with my matched cadet and that I must exercise care in supervising my cadet while we are together, I also understand and agree that I am not a Youth Challenge Academy agent, and that I am responsible for choosing and conducting all activities with my cadet. Youth Challenge Academy will not control how these activities are conducted, except to ensure that they are done in the interest of the mentoring relationship.

I therefore agree that Youth Challenge Academy will not be liable for, and agree to hold Youth Challenge Academy harmless from and all liability, causes of action and losses imposed on it in any way relating to or arising out of this mentoring agreement.

I further release Youth Challenge Academy from all liability, claims, demands, or actions whatsoever arising out of any damage, loss or injury I might incur while participating in any of the activities contemplated by thus mentoring agreement.

CONFIDENTIALITY AGREEMENT

Confidentiality is the preservation of the privileged information concerning the cadet. Most of the information that you gain about the cadet is CONFIDENTIAL; in terms of the law, disclosure could make you legally liable, or the disclosure may violate the trust that the cadet has developed with you, causing damage to your mentoring relationship. ALL record dealing with cadets must be treated as CONFIDENTIAL.

MENTOR AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize and consent to release of information and records bearing on my personal history, arrests, and convictions, in any way to the Youth Challenge Academy. This information will be used for determining my eligibility as a MENTOR with the Hawaii National Guard Youth Challenge Academy. I fully understand that the information collected may be sensitive, and will remain confidential. I hereby release the Hawaii National Guard Youth Challenge Academy and its agents from and liability and damage that may result for the exchange of requested information between law enforcement departments and the Hawaii National Guard Youth Challenge Academy.

FULL NAME			
ANY OTHER NAMES USED			
SOCIAL SECURITY NUMBER		ETHNIC GROUP	
DATE OF BIRTH		GENDER: M / F	

STATE YOU CLAIM RESIDENCY: _____ FROM: _____ TO _____

LIST ANY OTHER STATES YOU LIVED IN:

1. _____ FROM: _____ TO _____
2. _____ FROM: _____ TO _____

Print: _____

Signature: _____ Date: _____

MENTOR REFERENCE QUESTIONNAIRE

To: (PRINT) _____ (Reference)

From: (PRINT) _____ (Mentor Prospect)

I am applying to be a volunteer mentor for the Hawaii National Guard Youth Challenge Academy. I will be working with a youth between the ages of 16-18 years old. The goal is to be a support and a resource for the plans they want for their future.

Please circle all that apply: 1) An employee/former employee 2) Personal 3) Professional

1. How long have you known this person? _____

Please indicate where this person falls on the below listed scales by circling a number (1 = least, 5 = most, if unknown, denote 'unknown')

2. DEPENDABILITY (Keeps commitments, is on time, follows through):

1	2	3	4	5	
Unreliable			**Dependable**		**Unknown**

3. FLEXIBILITY (Adapts of changing situations, accepts people who have different values and lifestyles, is open to changes in routine):

1	2	3	4	5	
Rigid			**Flexible**		**Unknown**

4. SELF CONFIDENCE (Is secure, open, not afraid to take risks, can be assertive):

1	2	3	4	5	
Insecure			**Self Confident**		**Unknown**

5. INTERACTION WITH OTHERS (Gets along well with others, handles conflict effectively)

1	2	3	4	5	
Interacts poorly			**Interacts Well**		**Unknown**

6. What are this person's primary strengths?

_____

_____

7. What information can you provide regarding this person's interactions with young people?

_____

_____

Additional Comments:

_____

_____

Signature: _____ **Date: _____**

Telephone number: _____ **Email: _____**

MENTOR REFERENCE QUESTIONNAIRE

To: (PRINT) _____ (Reference)

From: (PRINT) _____ (Mentor Prospect)

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3. FLEXIBILITY (Adapts of changing situations, accepts people who have different values and lifestyles, is open to changes in routine):

1	2	3	4	5	
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1	2	3	4	5	
Insecure			**Self Confident**		**Unknown**

5. INTERACTION WITH OTHERS (Gets along well with others, handles conflict effectively)

1	2	3	4	5	
Interacts poorly			**Interacts Well**		**Unknown**

6. What are this person's primary strengths?

_____

_____

7. What information can you provide regarding this person's interactions with young people?

_____

_____

Additional Comments:

_____

_____

Signature: _____ **Date: _____**

Telephone number: _____ **Email: _____**