**Part I – Parent/Guardian Medical Form**

*Youth Challenge Academy Hawaii – Kapolei*

***(Entire Form Must Be Completed)***

1._____

**Last Name** **First Name** **Birthdate** **Male/Female**

2. Does the cadet have any medical diagnoses **confirmed** by a physician at some time in their life?

_____

3. Does the child take any current medication? (include all medication, OTC as well) **YES | NO**

| Medication Name(s) | Dosage(s) | How Often Medication Is Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

4. Any Allergies to Mediation/Food/Other: _____

*****If you answered "yes" to questions 3 & 4, Please ask the Medical Department for the "Medication/Allergy Form" &/or "Hawai'i Child Nutrition Program Form". This form needs to be filled out by Parent and Physician.***

5. Any **surgeries/hospitalizations** in the past (Reason and Date): _____

6. Has the Cadet ever been referred to Anger Management/Behavioral Health? **YES / NO**

7. Does your child see a Therapist, Psychologist, and/or Psychiatrist? **YES / NO**

Name: _____ Phone: _____

8. Sometimes medications are prescribed by physician, do you give the YCA Academy Medical Department/staff permission to administer these medications to your child? **YES | NO Initials** _____

9. I give permission for the YCA Medical Department to share cadet health information with YCA staff as appropriate, to help care for the cadet while at the academy? **YES | NO Initials** _____

I have answered the questions truthfully and to the best of my knowledge. Any changes must be reported immediately to Youth Challenge Academy Medical Department.

_____ _____ _____

**Print Name** **Signature** **Date**

## Part II – Candidate Medical Form

Do you currently smoke cigarettes/vape? **YES | NO** How many packs/cigarettes per day? _____

Will you need assistance to quit, nicotine patches while at the academy? **YES | NO**

Have you ever used any of the following drugs, and if so when was the last use?

| DRUG | YES | NO | How Long? | LAST USE (Days, Weeks, Months, Years) |
|---|---|---|---|---|
| Cocaine | | | | |
| Methamphetamine | | | | |
| Heroine | | | | |
| Prescription Drugs/Pain Pills | | | | |
| Marijuana | | | | |
| Alcohol | | | | |
| Other: | | | | |

Are you interested in cutting back or stopping the use of the above drugs? **YES | NO**

Have you ever self-inflicted pain to yourself? **YES / NO**

Have you ever attempted suicide? **YES / NO**

Have you ever had thoughts of ending your life? **YES / NO**

Do you want to attend the Youth Challenge Program? **YES / NO**

Why? _____

I have answered the questions above truthfully and honestly to the best of my knowledge.

| _____ | _____ | _____ |
|---|---|---|
| Print Cadet Name | Cadet Signature | Date |

### FOR MEDICAL DEPARTMENT USE ONLY

| | | |
|---|---|---|
| **Medical Review/Interview Date & Initial** | | **Comments:** |
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"This institution is an equal opportunity employer"

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