Discovery ChalleNGe Academy

Interview Date:_____

Interview Time:_____

Interview Location:
700 Roth Rd
Lathrop, CA 95330
916-616-7364

Dear applicant:

The documents listed below are required to complete your application. If all required documents are not Submitted by your assigned deadline, we will NOT be able to accept or process your application. Please Submit all documents to admissions@iamdiscovery.org.

Documents Required:

- ☐ Online Application (Website: iamdiscovery.org)
- ☐ Copy of U.S. Birth Certificate AND Social Security Number
- ☐ Most Recent Unofficial School Transcript
- ☐ Copy of Health Insurance Card
- ☐ Physical on DCA forms (Signed and Stamped by Dr., RN, PA, No Chiropractors)
- ☐ Most Recent Immunization Record
- ☐ MCV4 Shot (Within 5 Years) Booster shot is required if Menactra shot was received before age 16
- ☐ TB Test with Negative Results (Must be within 1 year of class start date)
- ☐ Copy of Power of Attorney (Notarized)

If Applicable:

- ☐ Custody Documents
- ☐ Copy of Juvenile Records
- ☐ Most Recent and Complete School IEP to include PSY Report and Test Scores / 504 Plan
- ☐ Therapist / Psychiatrist Clearance Letter
- ☐ If born in a different country, provide authorized forms of documentation (see page 3)

If you have any questions, please contact the admissions department at admissions@iamdiscovery.org or by phone at 916-827-5007

Discovery ChalleNGe Academy

Lista De Documentos Requeridos

Estimado/a Solicitante:

Los siguientes documentos son requeridos para completar su aplicación. Si no se entregan todos los documentos requeridos antes de la fecha límite asignada, no podremos aceptar ni procesar su aplicación. Por favor, envié todos los documentos a admissions@iamdiscovery.org**.**

Documentos Requeridos:

- ☐ Aplicación en línea (Sitio Web: iamdiscovery.org)
- ☐ Copia de certificado de nacimiento Y seguro social
- ☐ Expediente académico más reciente
- ☐ Copia de Tarjeta de Seguro Medico
- ☐ Examen Físico en Formularios de DCA (Firmado Y Sellado por Dr., RN, PA. No quiroprácticos)
- ☐ Cartilla de vacunas más reciente
- ☐ Vacuna de MCV4 (Dentro de 5 Anos)
- ☐ Vacuna TDAP (Dentro de 10 Anos)
- ☐ Prueba de Tuberculosis con resultados negativos (Dentro de 1 Ano)
- ☐ Copia del poder Legal Medico (Certificar por Notario)

Si Es Aplicable:

- ☐ Documentos de Custodia (Si es aplicable)
- ☐ Copia De los registros Del tribunal de menores (Si es aplicable)
- ☐ IEP Plan Educativo Individual / 504 Plan (Si es aplicable)
- ☐ Terapeuta/Psiquiatra Carta de Autorización (Si es aplicable)
- ☐ Si nació en otro país, debe proporcionar un documento autorizado (consulte la página 4)

Si tiene alguna pregunta, por favor de comunicarse con el departamento de admisiones a admissions@iamdiscovery.org o por teléfono al 916-827-5007.

Are participants citizens or lawful permanent residents of the United States?

Ref: DoDI 1025.08 Section 3.3.a.(1)(a)

Inspected Item: Copy of U.S. birth certificate in completed cadet applications. Other forms authorized to prove citizenship include:

- Certificate of Citizenship (N560A, N-560AB, N645, N645A or N561)
- Certificate of Naturalization (N550, N570, or N578)
- Certification of Report of Birth; Certification of Birth Abroad (DS-1350 or FS-545)
- Consular Report of Birth Abroad (FS-240)

Other forms authorized to prove lawful permanent residency include:

- Permanent Resident Alien Card (I-551)
- Foreign passport stamped by the U.S. Government indicating that the holder has been "Processed for I-551"
- Permanent Resident Re-Entry Permit (I-327)
- Arrival Departure Record (I-94) with “Temporary I-551” stamp and holder’s photograph affixed
- Federated States of Micronesia and the Republic of the Marshall Islands passport accompanied by Form I-94
- Travel Document issued to Permanent Residents (I-327)
- Travel Document issued to Refugees (I-571)

¿Son los participantes ciudadanos o residentes legales permanentes de los Estados Unidos?

Ref.: DoDI 1025.08 Sección 3.3.a.(1)(a)

Artículo inspeccionado: Copia del certificado de nacimiento estadounidense en las solicitudes de cadete completadas.

Otros formularios autorizados para comprobar la ciudadanía incluyen:

- Certificado de ciudadanía (N560A, N-560AB, N645, N645A o N561)
- Certificado de naturalización (N550, N570 o N578)
- Certificado de informe de nacimiento; Certificación de Nacimiento en el Extranjero (DS-1350 o FS-545)
- Informe Consular de Nacimiento en el Extranjero (FS-240)

Otros formularios autorizados para acreditar la residencia permanente legal incluyen:

- Tarjeta de Residente Permanente Extranjero (I-551)
- Pasaporte extranjero sellado por el Gobierno de los EE. UU. que indique que el titular ha sido "Procesado para el I-551"
- Permiso de Reingreso de Residente Permanente (I-327)
- Registro de Llegada y Salida (I-94) con el sello "Temporal I-551" y la fotografía del titular
- Pasaporte de los Estados Federados de Micronesia y la República de las Islas Marshall acompañado del Formulario I-94
- Documento de Viaje emitido para Residentes Permanentes (I-327)
- Documento de Viaje emitido para Refugiados (I-571)

California Youth Challe*NG*e Academy Sports Physical Form

SECTION A (to be completed by STUDENT):

☐ CAJC ■ DCA ☐ GYA ☐ SYA

NAME OF STUDENT (LAST, FIRST, MIDDLE):			SOCIAL SECURITY NUMBER:	
ADDRESS:			DATE OF BIRTH (MM/DD/YYYY):	
CITY:	STATE:	ZIP CODE:	SEX:	AGE:

MEDICAL HISTORY (PAST & CURRENT) PLEASE CHECK YES OR NO FOR EACH MEDICAL CONDITION. IF YOU CHECK YES, WRITE THE YEAR IN THE BOX, AND **HAVE THE PHYSICIAN EXPLAIN IN SECTION B.**

	YES	NO	YEAR		YES	NO	YEAR		YES	NO	YEAR
ASTHMA				EATING DISORDER				GALL BLADDER TROUBLE			
SHORTNESS OF BREATH				RECENT WEIGHT GAIN/LOSS				GALLSTONES			
CHEST PAIN/PRESSURE				SWOLLEN /PAINFUL JOINTS				JAUNDICE OR HEPATITIS			
CHRONIC COUGH				ARTHRITIS/RHEUMATISM				SKIN DISEASE/INFECTION			
HEART PALPITATION				BURSITIS				TUMOR/GROWTH/CYST			
POUNDING HEART				BONE/ JOINT DEFORMITY				CANCER/ CHEMOTHERAPY			
HEART TROUBLE				LOSS OF FINGER/TOE				RADIATION THERAPY			
LOW BLOOD PRESSURE				BROKEN BONES				HERNIA			
HIGH BLOOD PRESSURE				PAINFUL/"TRICK" SHOULDER				HEMORRHOIDS			
FREQUENT HEADACHES				PAINFUL/"TRICK" ELBOW				RECTAL DISEASE			
SEVERE HEADACHES				LOCK/"TRICK" KNEE				FREQUENT URINATION			
DIZZINESS				BACK PAIN				PAINFUL URINATION			
FAINTING SPELLS				ANY TYPE OF BACK INJURY				BED WETTING SINCE AGE 12			
MEMORY LOSS/AMNESIA				BACK BRACE				KIDNEY STONE			
UNCONSCIOUSNESS				WRIST BRACE				BLOOD IN URINE			
HEAD INJURY/CONCUSSION				KNEE/ANKLE BRACE				BLOOD DISORDERS			
SINUSITIS				CRAMPS IN YOUR LEGS				DIABETES TYPE I			
WEAR CORRECTIVE LENSES				FOOT TROUBLE				DIABETES TYPE II			
EYE SURGEY				PLATE/PIN/ROD IN BONE				SLEEPWALKING			
NO VISION IN EITHER EYE				NERVE INJURY				TROUBLE SLEEPING			
EYE TROUBLE				HISTORY OF PARALYSIS				PSYCHIATRIC ISSUES			
WEARING A HEARING AID				EPILEPSY OR SEIZURE				DEPRESSION			
HEARING LOSS				CAR/SEA/AIR SICKNESS				SUICIDE ATTEMPT			
EAR INFECTIONS				FREQUENT INDIGESTION				HOSPITALIZATIONS			
TOOTH/GUM TROUBLE				STOMACH TROUBLE				HISTORY OF COUNSELING			
THYROID TROUBLE				INTESTINAL TROUBLE				HISTORY OF THERAPY			
GOITER TROUBLE				LIVER TROUBLE				POSITIVE TUBERCULOSIS			
HISTORY OF ANEMIA											

SECTION B (to be completed by licensed physician, physician assistant, nurse practitioner):

PLEASE EXPLAIN ANY REPORTS OF MEDICAL ISSUES AS REPORTED IN THE MEDICAL HISTORY SECTION A. IF POSITIVE TB, DESCRIBE TREATMENT AND PROVIDE A CHEST X-RAY REPORT DONE AFTER 11 July 2025

SECTION B (continued):

PHYSICAL EXAM (NAME OF STUDENT):

DATE OF EXAM:	HEIGHT (IN):	WEIGHT (LB):	BLOOD PRESSURE:	HEART RATE:

PLEASE LIST ANY FOOD ALLERGIES:	TYPE OF REACTION:
PLEASE LIST ANY MEDICATION ALLERGIES:	TYPE OF REACTION:

PLEASE LIST ANY CURRENT MEDICATIONS:	DOSAGE:	ROUTE:

IF HISTORY OF ASTHMA, IS INHALER NEEDED: ☐ YES ☐ NO ☐ N/A

(if yes, aero chamber must be prescribed)

RECENT OR PAST HISTORY OF PHYSICAL THERAPY: **IF YES, EXPLAIN & PROVIDE DOCUMENTATION:** _____	☐ YES ☐ NO
SEEING A THERAPIST, PSYCOLOGIST, COUNSELOR, REHABILITATION FOR DRUGS: **IF YES, EXPLAIN & PROVIDE DOCUMENTATION:** _____	☐ YES ☐ NO
IS THERE ANY OTHER MEDICAL ISSUES THAT WE SHOULD BE AWARE OF: **IF YES, EXPLAIN:** _____	☐ YES ☐ NO

PLEASE PROVIDE A COPY OF THE STUDENT'S UPDATED IMMUNIZATION RECORD. STUDENT MUST HAVE THE FOLLOWING IMMUNIZATIONS FOR ADMITTANCE INTO A CHALLENGE YOUTH ACADEMY:

Tdap (Adacel within 10 years)
Meningococcal Group B
MMR 1 AND 2
TB Test (administered after 1 February 2026)
If positive TB Test, a chest x-ray report must be done.
Seasonal Flu
MCV4 Booster
HPV
Varicella

THE STUDENT CAN FULLY PARTICIPATE AT A CHALLENGE YOUTH ACADEMY WITHOUT ANY PHYSICAL RESTRICTIONS.	☐ YES ☐ NO

TYPED OR PRINTED NAME OF PHYSICIAN: **(MUST BE MD, DO, PA, NP)**	**STAMP OF EXAMINING FACILITY:**
SIGNATURE	
DATE:	

Discovery ChalleNGe Academy

Special Power of Attorney for the Authorization of Medical Care and Medical Expense Statement
THIS FORM NEEDS TO BE NOTARIZED

KNOWN ALL MEN/WOMEN BY THESE PRESENTS:

That I_____, Date of birth ___/____/_____ID # _____
Guardian (or Student if 18 years old) *(Guardian's, or Student's if 18 years old, CA ID #/Residency Card #)*

Am a legal resident of_____County, California, hereby appoint the director of Discovery
(Name of County)
ChalleNGe Academy, located at Sharpe Army Depot, Lathrop, CA, as my true and lawful attorney-in-fact to do the following in my name and in my behalf:
Anything necessary to maintain (my health) the health of my child*, _____. I want my attorney-in-fact to
***If 18 years old enter "N/A".**
Have the power to consent to any medical or dental treatment needed for my child and to sign any papers needed to authorize those treatments. I want my attorney-in-fact to be able to do anything I could do if I were personally present. Anything my attorney-in-fact does to maintain the health of my child (my health) will be the same as if I had done it myself. This is a Durable Power of Attorney. It will stay in effect if I become disabled, incapacitated or incompetent. This Power of Attorney shall expire after the 22 week residential phase is completed or the Cadet withdraws or is terminated from the Academy.

Medical Expenses Statement of Understanding

The medical staff at the Discovery ChalleNGe Academy consists of a Medical Doctor, P.A, and RNs. They will make all necessary medical determinations regarding current cadets. Discovery ChalleNGe Academy **DOES NOT** pay for normal medical expenses incurred by your cadet. The cadet, and ultimately the parent/guardian, regardless of insurance coverage, is responsible for all normal medical and dental expenses, to include all co-payments, deductibles, and all non-covered charges. The Academy will provide physician, hospital, or pharmacy needs with the appropriate insurance information or Medical or Medicaid coverage.

IN WITNESS WHEREOF, I have affixed my signature hereto this_____day of _____20_____

Signature_____
Guardian (or Student if 18 years old)

********** TO BE COMPLETED BY NOTARY **********

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

STATE OF CALIFORNIA, COUNTY OF _____)

On _____before me, _____,

personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity (ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature: _____ **(Seal)**

Behavioral Health Requirement

IF APPLICABLE, PLEASE PRESENT THIS FORM TO YOUR THERAPIST/PSYCHIATRIST IN ORDER FOR THEM TO ASSIST YOU IN SECURING THE DOCUMENTS NEEDED TO BE CONSIDERED FOR THE DISCOVERY CHALLENGE ACADEMY.

The client presenting this letter is now **applying** to the Discovery ChalleNGe Academy Program and the on-site high school for a period of 5 ½ months (July-Dec. or Jan-June). This is an intervention and will be a temporary school assignment for students 16-18 years of age. (Receipt of these documents does not mean the student is accepted at this time).

Please provide the client with a letter completely detailing *each* of the requirements listed below so that he/she can turn it in as part of their application.

- Client's current diagnosis
- Client 's former diagnosis (es), if applicable
- Treatment plan for client (to include frequency of sessions, goals, client's progress, etc.)
- Any corresponding psychiatric services (To include Psychiatrist's name/contact information, current medications and dosage, history of medication management/client's responsiveness to medication, etc.)
- Treating Therapist/Psychiatristt's professional opinion on the mental/emotional stability of the client and his/her ability to complete this program (Note: this program is a 5 ½ month, quasi-military structured program, with strict adherence to discipline/rules/order and encompasses a high stress environment).

*Note: If the client has ever been admitted to a hospital for behavioral health reasons, a complete psychological evaluation from the time of the hospitalization will be required **IN ADDITION TO** the letter provided by the current treating Therapist/Psychiatrist.

If you have any questions or need clarification regarding the Academy review process related to behavioral health only, please contact Discovery ChalleNGe Academy Clinician Bernadette Ortiz at (209) 986-1354 or Bortiz@sjcoe.net. Alternative contact is Lead Medic SSG Peterson 916-616-7624 or peterson@iamdiscovery.org .

Sincerely,

Discovery ChalleNGe Academy
P.O. Box 1189
Lathrop, CA 95330-1189

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Blood Draw Service Fee	$115
*Add titer price to blood draw fee	
Hepatitis B Titer	$10
Hepatitis C Titer	$6
MMR Titer	$26
Varicella Titer	$6
Urine Drug Test (5-12 Panels)	$55
5 Panel Hair Drug Test	$100
Saliva Alcohol Test	$10
Custom Drug/Blood Tests	Call

VACCINES

Flu	$50
Hepatitis A	$145
Hepatitis B	$140
MMR	$140
Polio	$90
TDap	$100
Varicella	$225

PHYSICALS/RELATED TESTS

Employment Physical	$85
Foster Physical	$85
School Physical	$85
Ishihara Vision Test	$25
Audiometric Hearing Test	$85
I-9 Verification	$30
Employee Photo/Passport Photos	$10

FINGERPRINTS/BACKGROUND

Livescan	
Rolling Fee	$30
Government Fees (Varies)	Call
Fieldprint	Call
IdentoGO	Call
Accurate Biometrics	Call
Background Screening	Call

County Search, National Criminal, Social Security Trace, DMV, FACIS/OIG, Credit Checks

RESPIRATORY/OSHA

OSHA Respirator Clearance	$20
N95 Mask Fit	$55
FIT Testing (half/full face)	$95
Spirometry Lung Function	$85
Asbestos Screening Physical	Call
Silica Screening Physical	Call

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