KENTUCKY YOUTH CHALLENGE
STUDENT APPLICATION

Thank you for your interest in Kentucky Youth Challenge
Our classes begin every January and July. This is a chance of a LIFETIME!!

Applications are accepted on a first come first serve basis, with limited spots available.
Please do not wait until the last minute to apply!

Appalachian ChalleNGe Academy

Appalachian ChalleNGe Academy
465 Grays Drive, PO Box 539
Grays Knob, KY 40829
1-855-596-4927
Fax: 1-606-574-0362
www.ChalleNGeACA.com
admissions@challengeaca.com

www.facebook.com/acaharlan

@Challenge_ACA

Eligibility requirements for our program:

- 16, 17, or 18 years of age upon entry
- A youth who is struggling in school or no longer attending school and who has not received a high school diploma or a GED
- No pending felony charges or felony convictions
- Resident of Kentucky
- Mentally and physically capable to participate in the program
- Volunteer to attend program
- Be free of illegal drugs (Candidates will be tested for drug use)
- Unemployed or underemployed

Directions and packing list will be forwarded after acceptance has been established to the program.

Application Instructions-Read Carefully

If you have questions about filling out the application, please contact the Academy. We recommend that you keep a copy of your entire application.

NOTE – Application should not be signed until in the presence of a admissions coordinator
Notary will be completed at your interview.

By typing my name in the boxes below I am offering my digital signature in lieu of my handwritten signature. I understand that my digital signature carries the same legal bindings as my handwritten signature. Initials:_____

Do Not Send a check or Money Order with the Central Registry Check.

Revised Kay 22, 2021

APPLICATION CHECKLIST

Pg. # **Incomplete applications will not be accepted!**

3-4. Applicant & Parent/Legal Guardian information sheet

5-7. Report of Medical History (Include documentation or explain questions 10 & 11)

8. Insurance Information

9. Legal Infromation (Law Violations)

10. Special Power of Attorney Authorizing Medical Care and Expenses.

11. Certificate of Understanding, Release of Liability, and Release of Information

12. Release of Information Letter

14-18 Mentor Application

Central Registry Background Form

Supporting Documents

Copy of Official Birth Certificate (do not send original)

Copy of Social Security Card (do not send original)

Copy of Front and back of Medical Insurance Card(s) (do not send original)

Copy of Immunization/Shot record (do not send original and tetanus needs to be up to date)

Copy of High School Withdrawal Form

Copy of High School Transcript, Must be on hand not later than Day 15

Dental work, eye exams, and medication needs should be taken care of before coming to Kentucky Youth Challenge.

PRESCRIPTION MEDICATION WILL NOT BE ACCEPTED IF IT IS OLDER THAN 30 DAYS, THIS INCLUDES MEDICATION IN A BOTTLE. NO EXCEPTIONS!! Please do not send vitamins or any over the counter medication. If the applicant takes medication, he/she must come with a 30 day supply!

APPLICANT INFORMATION SHEET

Applicant's Information: Print Clearly and fill in ALL of the information

Today's Date: _____ Social Security#_____

Have you applied here before Yes☐ No☐ If Yes, when:_____

Last Name_____ First Name_____ MI_____

Date of Birth_____ Age:_____ Gender: ☐Male ☐Female

Last Public School Attended_____

Last Day of Attendance_____ Highest Grade Completed_____

Are you employed? ☐ Yes ☐ No If Yes, Occupation_____

Ethnicity (Must Check One) ☐ American Indian/Alaskan Native ☐Asian/Pacific Islander

☐Black ☐Hispanic ☐White Religion_____

Married ☐Yes ☐No Number of Children_____

Are you currently free from illegal drugs and/or alcohol: ☐ Yes ☐No

Applicant's Contact Information

Home Phone_____ Email_____

Address_____

City_____ County_____ State_____

Zip_____

Please provide a copy of the applicants High School Transcript and Official Withdrawal Form after he/she is withdrawn from school.

I certify that_____ (applicant) is not a high school graduate, does not have an alternative certificate or GED, and is no longer attending school _____ (initial) or the last day of attendance will be _____(date)_____(initial).

PARENT/LEGAL GUARDIAN INFORMATION SHEET

Parent/Guardian Information

A. Relationship to Applicant: _____

Last Name_____ **First Name**_____ **MI**_____

Home Phone_____ **Work Phone**_____

Cell Phone_____ **Email**_____

Address_____

City_____ **County**_____ **State**_____

Zip_____

Is this Person Authorized for pickup? ☐ **Yes** ☐ **No**

Legal Guardian? ☐ **Yes** ☐ **No** **Emergency Contact?** ☐ **Yes** ☐ **No**

_____

B. Relationship to Applicant: _____

Last Name_____ **First Name**_____ **MI**_____

Home Phone_____ **Work Phone**_____

Cell Phone_____ **Email**_____

Address_____

City_____ **County**_____ **State**_____

Zip_____

Is this Person Authorized for pickup? ☐ **Yes** ☐ **No**

Legal Guardian? ☐ **Yes** ☐ **No** **Emergency Contact?** ☐ **Yes** ☐ **No**

REPORT OF MEDICAL HISTORY

Last Name_____ First Name_____ MI_____

ANSWER ALL QUESTIONS, PUT N/A IF THE QUESTION DOES NOT PERTAIN TO YOU. FAILURE TO DISCLOSE KNOWN ISSUES COULD RESULT IN DENIAL OF ENROLLMENT

1. Statement of Health: Good ☐ Fair ☐ Poor ☐

Explain_____

2. Current Medication(s)

Name	Dose	Time(s) Given
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. In the past two years, has the applicant taken any type of medication that he/she no longer takes (DO NOT include over-the-counter medication & anti-biotics that he/she is no longer taking)
Yes ☐ No ☐
If Yes, list what type and why the applicant stopped taking the medication:_____

_____

4. Allergies (INCLUDE INSECT BITES, COMMON FOODS, AND MEDICATIONS)

_____

_____

5. Ht _____ Wt _____ Eye Color _____Hair color _____

6. Physcian Name:_____ Phone:_____

7. Psychiatrist/Psychologist Name:_____ Phone:_____

8. Dentist Name: _____ Phone:_____ Last Exam: _____

REPORT OF MEDICAL HISTORY (CONT)

9. Braces? ☐ Yes ☐ No

Orthodontist Name_____ Phone_____

10. Glasses? ☐ Yes ☐ No

Optometrist Name_____ Phone_____

11. Have you ever been hospitalized for an illness or injury ☐ Yes ☐ No

If so; when, where, and why? _____

_____

*12. Have you ever consulted or been treated by a psychiatrist, psychologist, therapist, and/or counselor? ☐ Yes ☐ No

If yes, please choose one: ☐ Comp Care ☐ Private Practice ☐ Other

Name/Phone Number:_____

Reason: _____

_____

*13. Have you been hospitalized in the last 12 months for any illness, injury, and/or mental disorder? ☐ Yes ☐ No If yes: Date:

Reason:_____

_____

**14. Have you had a broken bone in the last 6 months? ☐ Yes ☑ No

If yes: Date: _____

If so, Describe what happened: _____

_____

*Note: If you answered "YES" questions 12 and 13, and it has been in the last 12 months, all records must be sent with your application

**If you answered yes to question 14 you must provide a doctors release with your application

REPORT OF MEDICAL HISTORY

Last Name:_____ First Name_____

MI_____CHECK ALL OF THE ITEMS THAT APPLY NOW OR THAT YOU HAVE EVER EXPERIENCED. SELECT CURRENT IF THE CONDITION IS WITHIN THE LAST 12 MONTS. SELECT PAST IF THE CONDITION OCCURRED OUTSIDE OF 12 MONTHS. P = PAST/C= CURRENT

P / C		P / C		P / C	
☐☐	Thyroid trouble/goiter	☐☐	Eye/ear/nose/throat trouble	☐☐	Adverse reaction to medication
☐☐	Bone/joint deformity	☐☐	Frequent indigestion	☐☐	Chronic/frequent colds or coughs
☐☐	Skin disorders	☐☐	Pregnant at this time	☐☐	Depression or heavy weeping
☐☐	Sinusitis/hay fever	☐☐	Paralysis	☐☐	“Trick” knee/shoulder/elbow
☐☐	Tumor/growth/cyst/cancer	☐☐	Nose bleeds	☐☐	Obsessive Compulsive Disorder
☐☐	Lameness or neuritis	☐☐	Behavior Disorder	☐☐	Oppositional Defiant Disorder
☐☐	Nervous disorder	☐☐	Stomach/intestinal	☐☐	Sexually Transmitted Disease
☐☐	Bi-Polar	☐☐	Epilepsy/seizures/fits	☐☐	Asthma/shortness of breath
☐☐	Broken bones	☐☐	Gall bladder trouble	☐☐	Treated for female disorders
☐☐	Rupture/hernia	☐☐	Jaundice/hepatitis	☐☐	Severe tooth or gum trouble
☐☐	Rectal disorder	☐☐	Motion Sickness	☐☐	Change in menstrual cycle
☐☐	ADD/ADHD	☐☐	Bleeds easily	☐☐	Painful/frequent urination
☐☐	Coughed up blood	☐☐	Arthritis/rheumatism	☐☐	Dizziness/fainting spell
☐☐	Anemia/Sickle Cell	☐☐	Recent gain/loss of weight	☐☐	Palpitation/pounding heart
☐☐	Attempted suicide	☐☐	Liver disorder/disease	☐☐	Kidney stone/blood in urine
☐☐	Leg/feet cramps	☐☐	Frequent trouble sleeping	☐☐	Frequent/severe headaches
☐☐	Recurrent back pain	☐☐	Diabetes/hypoglycemia	☐☐	Loss of finger/toe/arm/leg
☐☐	Knee brace/back support	☐☐	Had 1 or more children	☐☐	Sugar/albumin in urine
☐☐	Head injury	☐☐	Eating Disorder	☐☐	Heart trouble/murmur
☐☐	Swollen or painful joints	☐☐	Unconsciousness	☐☐	High/low blood pressure
☐☐	Bedwetting since age 12	☐☐	Sleepwalker	☐☐	Speech Impairment
☐☐	Scarlet/Rheumatic fever	☐☐	Loss of Memory/Amnesia	☐☐	Hearing Impairment
☐☐	Tuberculosis				

INSURANCE INFORMATION

Insurance Information: Include copy of front and back of insurance card.

Medical

Name of Insurance Company:_____

Subscriber's Name:_____

Subscriber's birthday:_____ Social Security #

Subscriber's place of work:_____

Insurance Company Address:_____

Insurance Company Phone:_____

Identification Number:_____

Group Number:_____

Pharmacy:

☐ FSA Card ☐ HRA Card ☐ Pharmacy Card

Card #_____ ID # _____ RX Group #_____

PCN # _____ RX Bin # _____ Pharmacist Call #_____

Dental

Dental Insurance Company Name:_____

Dental Insurance Phone:_____

Dental Insurance ID:_____

Vision

Vision Insurance Company Name:_____

Vision Insurance Phone:_____

Vision Insurance ID:_____

LEGAL INFORMATION

Last Name:__________________________ First Name:_______________________ MI_______

1. Have you ever been arrested and/or charged with a crime? ☐ Yes ☐ No
   If you answered "No", go to the next page

2. If you answered "Yes" to question #1, please complete the following:

Date:_______________________

Place of Offense: City_______________________ County_____________________________ State___________

Offense/Violation:____ ☐ Misdemeanor ☐ Felony

Name & Location of court:____

Penalty Imposed/Disposition____

Probation Officer: Name______________________________________ Phone__________________________

Date:_______________________

Place of Offense: City_______________________ County_____________________________ State___________

Offense/Violation:____ ☐ Misdemeanor ☐ Felony

Name & Location of court:____

Penalty Imposed/Disposition____

Probation Officer: Name______________________________________ Phone__________________________

Date:_______________________

Place of Offense: City_______________________ County_____________________________ State___________

Offense/Violation:____ ☐ Misdemeanor ☐ Felony

Name & Location of court:____

Penalty Imposed/Disposition____

Probation Officer: Name______________________________________ Phone__________________________

3. Are you Currently awaiting a hearing or sentencing? ☐ Yes ☐ No

4. If you are awaiting a hearing or sentencing, what is the scheduled date/time and city/county?

Date________________ Time_______________ City________________________ County_____________________

SPECIAL POWER OF ATTORNEY AUTHORIZING MEDICAL CARE & EXPENSES (Notarized Appointment of Attorney-in-Fact for Obtaining Health Care)

That I _____, as parent/legal guardian of _____
Guardian (or Applicant if 18 years of age) (Applicant's Printed Frist and Last Name)

A Cadet of the Kentucky Youth Challenge Academy, appoint the Kentucky Youth Challenge Academy, and it's authorized agents, as my attorney-in-fact for purposes of obtaining health care; medical treatment; and /or psychological treatment for the benefit of the cadet.

Authorization for Treatment by Youth ChalleNGe Academy Medical Staff – Specifically, I acknowledge the medical staff at Kentucky Youth ChalleNGe Academy consists of a Registered Nurse, a Licensed Practical Nurse and/or a contracted Medical Director. Determinations regarding appointments, administering treatments, medications, approved diagnosis and all other actions approved by the Medical Director will be carried out by the nursing staff in accordance with the laws of the State of Kentucky. In accordance with program requirements, I hereby authorize medical staff at Kentucky Youth ChalleNGe Academy to test my son/daughter for drugs, alcohol, STI, HIV, and pregnancy any time deemed necessary during the course of the program. I understand that a positive test result for drugs/alcohol will subject my child to immediate expulsion from the program.

Authorization for Treatment by Medical Care Providers – Further, I specifically authorize Kentucky Youth ChalleNGe Academy to act in loco parentis for the cadet to obtain the medical care and medical treatment deemed advisable or necessary to benefit and/or maintain the health of the cadet, to include but not limited to primary care, dental care, emergency care, and ophthalmology. I intend for the Kentucky Youth ChalleNGe Academy to perform any and all acts as fully to all intents and purposes as I might or could if were personally present: to authorize and provide for the care, maintenance, well-being and health including, but not limited to, authorizing any and all medical and hospital care and treatment, regardless of whether on an emergency basis, including major surgery deemed necessary by a duly licensed staff physician at any hospital whether within or without the territorial limits of the State of Kentucky. If my child becomes a danger to himself/herself, I hereby give my permission for necessary measures to be taken to maintain his/her safety which may include a referral for psychological evaluation and/or hospitalization.

Authorization for Distribution of Medication by Youth ChalleNGe Cadre – Further, I specifically authorize Kentucky Youth ChalleNGe Academy Cadre, under the instruction and supervision of Kentucky Youth ChalleNGe medical staff, to distribute over-the-counter and prescription medications to the cadet in accordance with those times and dosages set forth by the prescribing practitioner and/or the medical staff of the Kentucky Youth ChalleNGe Academy.

Intent to Hold Harmless – It is my intent that the Kentucky Youth ChalleNGe Academy and it's lawful agents, cadre, the medical facility and any doctors, nurses and other medical personnel involved in providing care or advice shall have no civil or criminal liability for honoring my wishes as expressed in this designation or for implementing the decisions of my attorney-in-fact.

Medical Expense Statement of Understanding- I acknowledge the Kentucky Youth ChalleNGe Academy **DOES NOT** pay for medical expenses incurred by the cadet if the injuries/illnesses are caused by cadet participating in a non-sanctioned Youth ChalleNGe activity and I acknowledge and agree I, as the parent/legal guardian, regardless of insurance coverage, am responsible for all medical and psychological expenses, to include all co-payments, deductibles, and all non-covered expenses. The Academy will provide physician, hospital or pharmacy needs with the appropriate insurance information or Medical or Medicaid coverage.

Durable Power of Attorney – Date of Expiration

I intend for this Appointment of Attorney-in-Fact for Obtaining Health Care to be a Durable Power of Attorney and to remain in effect if I become disabled, incapacitated or incompetent. **This Appointment of Attorney-in-Fact shall remain in effect form the _____ day of _____ 20 ___ until the cadet graduates from the Academy or is released from the Academy.**

_____	_____	_____
Applicant Signature	**Applicant Printed Name**	**Date**
_____	_____	_____
Parent/Legal Guardian Signature	**Parent/Legal Guardian Printed Signature**	**Date**

State of Kentucky, County of _____

Before me, a Notary Public in and for the State of Kentucky, personally appeared the above person(s) personally known to me and proved to me on the basis of satisfactory evidence, to be the person(s) whose name(s) is/are subscribed to this document and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity. IN WITNESS THEREOF, I have affixed my signature hereto this _____ day of _____, 20 _____.

_____	_____	_____
Signature of Notary Public	**Printed Name of Notary**	**Commission Expiration**

A resident of _____ Please Place Stamp/Seal here:

_____

CERTIFICATE OF UNDERSTANDING, RELEASE OF LIABILITY, & RELEASE OF INFORMATION

That I _____, as parent/legal guardian of _____
Guardian (or Applicant if 18 years of age) (Applicant's Printed Frist and Last Name)

Having applied for enrollment with the Kentucky Youth ChalleNGe Academy hereby certify:

1. **That I permit my child to participate in all Academy activities which may include UNIQUE activities such as rappelling, ropes course, aircraft rides (to include military aircraft), extreme physical activities, and various off campus activities; to include transport to and from such events and travel in and outside of Kentucky in various types of vehicles. This release shall remain in effect for the 17 ½ month duration of both the Residential and Post-Residential program.**
2. **The Academy has my permission to search my child and their personal belongings for contraband upon arrival for intake, after any outing off-campus, and randomly if deemed necessary throughout the Residential Phase. Random searches may also be conducted if warranted in conjunction law enforcement officials and any trained staff due to being a drug-free program.**
3. **That the Academy has my permission to release photographs of my child to the media and non-confidential information of my child to the same for publicity purposes.**
4. **That the Academy has permission for my child to participate in the TABE, ASVAB, ACT, SAT, GED, or any other academic related tests.**
5. **That I give my permission for my child to receive counseling services from the Kentucky Youth ChalleNGe personnel. Services may include mental health and/or substance abuse counseling, and psychological/educational tests.**
6. **That I give my permission for the Academy staff to maintain discipline by imposing disciplinary measures upon my child.**
7. **That I give my consent for the release of the following information records to Kentucky Youth ChalleNGe: intake, psychological, and psychiatric evaluations or tests; medical history/record; substance abuse history/record; juvenile court records; penal institution; treatment notes and summaries; school records (transcripts, IEP records, etc.); other records deemed necessary for successful evaluation of the child's participation in the program.**

   Furthermore, in consideration of my child's participation in the Academy, I HEREBY RELEASE the State of Kentucky, the officers, agents, employees, successors, and assigns from any and all liability which may arise from my child's participation in the Academy. I AGREE to hold harmless the State of Kentucky National Guard, the National Guard Youth ChalleNGe Program, the officers, agents, employees, successors, and assigns regarding any liability or cause of action which may arise from my child's participation in the Academy.

WORKERS COMPENSATION STATUS: All cadets are neither considered federal employees nor are they a member of the National Guard except under certain provisions of the law. They shall be considered federal employees for the purposes of compensation for work related injuries, or relating to the liability of legal conduct of employees of the United States. No Cadet will be considered to be in performance of duty while not at the assigned location of training or other activity authorized by the program agreement except while the Cadet is traveling or is on a pass or any other activity. All Cadets when receiving benefits for disability or death, the monthly pay that is received will be under the salary for a grade GS-2 federal employee. Further, Cadets must understand the entitlement to receive compensation for disability will begin on the day following the date the persons participation terminates from the program.

PRIVACT ACT: "Personal Information is required and protected under the Privacy Act of 1974. Kentucky Youth ChalleNGe operates as an entity of state government, organized under state law. Data for program operations is required and protected under Public Law 102-484, Section 1091 e (2). Disclosure is voluntary, however; persons failing to provide the information requested on this document will not be considered for participation in the program. Information provided on this application and generated during residential and post-residential performance will only be used by the program to meet federal and state requirements and will not be released to any party outside the Youth ChalleNGe organization, our inspectors/evaluators, or based upon requirements dictated by competent legal authority."

UNAUTHORIZED ABSENCE: "I understand that all Kentucky Youth ChalleNGe participants are there as volunteers and regardless of the training location agree to follow the rules and guidelines of the program and the instructions of staff supervising their activities. I understand that every effort of the supervising staff is intended to ensure cadets operate in a safe, secure, and managed environment. I understand that if my child chooses to absent himself from planned activities, there is little the program can do to absolutely prevent this type behavior. I also understand that immediately upon any action my child takes to absent themselves from program activity or supervision without proper authority, I absolve Kentucky Youth ChalleNGe of any liability due to this action. I understand Kentucky Youth ChalleNGe will take immediate steps to locate my child once the absence is identified, will notify me at this point, and will process a missing person's report with all local authorities. I also understand that any participant who is absent without proper authority for more than 24 hours may be terminated from attendance."

_____	_____	_____
Applicant Signature	**Applicant Printed Name**	**Date**
_____	_____	_____
Parent/Legal Guardian Signature	**Parent/Legal Guardian Printed Signature**	**Date**

RELEASE OF INFORMATION LETTER

Last Name:_____First Name:_____ MI:_____

Social Security #_____ DOB:_____

I consent for the release of the information requested below from the staff at the Challenge Academy.

Parent/Legal Guardian's Signature_____

Date_____

(This authorization shall remain effective from one year from date of signature)

ACADEMY USE ONLY

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The LEGAL GUARDIAN hereby authorizes release of the following information records to Kentucky Youth Challenge:

- Intake, psychological, psychiatric evaluations
- Medical History/Record
- Substance Abuse (alcohol/drug abuse)
- Psychological Testing
- Other

Juvenile Court Records

- Penal Institution
- Treatment notes and summaries
- School records (IEP reports, etc.)

To: (Name/Title)_____

Agency: _____

Address: _____

City:_____State:_____Zip:_____

I consent to the release to provide essential background information to assess the needs of the cadet requiring assistance in counseling and to coordinate or facilitate social/community services.

CHALLENGE ACADEMY REPRESENTATIVE DATE

_____ _____