To: Parent and/or Guardian

From: Freestate ChalleNGe Academy Medical Department

Subject: Everything Required by Medical Department.

Below is a list of everything required by the Medical Department for in-processing.

FORMS TO BE COMPLETED BY PARENT AND/OR GUARDIAN

- How to Have Your Child Medically Prepared
- Medical History Form
- Parental Consent for Medical Care (To Be Completed at Time of Interview)
- Psychological History

FORMS TO BE COMPLETED BY PHYSICIAN

- Medical Evaluation of Student for Participation in the Academy
  * Exam Must Be **LESS** Than 9 (NINE) Months Old at Class Start Date
  * PPD (tuberculin test) Results Must Be Annotated on Physical Exam
- Physician's Authorization for Prescription & OTC Medication
  Note: ONE FORM FOR EACH MEDICATION (prescription &/or non-prescription).
- Completed **MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE FORM 896**, ...no other form is acceptable... to include completed:
  * Hepatitis B series (all 3 shots)
  * Current tetanus booster (less than 10 years old)
  * Meningococcal
  * Varicella (or date of history of disease)
  * MMR (proof of two shots)
  * If starting in the **January class** you must have a current **FLU** vaccination.

  All applicants must meet Maryland State immunization requirements for entrance into Freestate ChalleNGe Academy.
- Copy of Signed Over-The-Counter (OTC) Formulary to be completed by the parent/guardian **and** the physician
- STD Screening Information Form

IF ANY OF THE ABOVE ITEMS ARE NOT COMPLETED BY IN-PROCESSING DAY YOUR CHILD WILL NOT PROCESS.
YOUR CHILD WILL HAVE TO REAPPLY FOR THE FOLLOWING CLASS.
IF YOU HAVE ANY QUESTIONS CONCERNING THE MEDICAL FORMS PLEASE CONTACT THE MEDICAL DEPARTMENT AT 410-436-3236

MEMORANDUM FOR PARENTS/GUARDIANS
FROM: Medical Section
SUBJECT: How to Have Your Child Medically Prepared

1. Make sure that your child has had all necessary medical appointments before the scheduled in-processing date.

a. **DENTAL APPOINTMENTS**: Make sure routine dental appointments are made before or after the program ends. Dental appointments will only be made in emergency situations. All other appointments will be made after the program ends. If cadet is having Orthodontic follow-up, please make sure they have a visit scheduled prior to start of program and have a statement from the Orthodontist concerning how many weeks before the next follow-up. Do not schedule a date. Follow-up dates must be coordinated with the medical department and can only occur on non-academic days.

b. **MEDICAL APPOINTMENTS**: Will be made through the medical department. Your child can be picked up on the day of the appointment and must return immediately following appointment. Medical appointments can only occur on non-academic days.

c. **EYE APPOINTMENTS**: Please make sure that your child has had their routine eye exam before entering the program. Make sure they bring current prescription glasses with them. Glasses that "darken" when the child goes outside are NOT authorized. Non-emergency routine follow-up eye appointments will only be made after the program ends.

d. **CONTACT LENSES**: If your child has contact lenses they must get prescription glasses for the program. Contact lenses are not authorized. Students are not allowed to have contact lenses while at the Academy due to the increased risk of infection. Glasses must be clear lens and cannot darken in the sunlight.

2. If your child is currently taking any prescription medication(s) please continue these medications. Do not stop medications unless directed by your physician.

a. PRESCRIPTION MEDICATIONS: Please remember to bring all prescribed medication and medication authorization forms (filled out by your physician) to in-processing.

b. If over-the-counter medications are taken on a regular or seasonal basis, a medication authorization form must be filled out & signed by your physician.

Please sign below to verify that you reviewed and understand the procedure for medical appointments.

Sign _____ Date _____

MEDICAL HISTORY
TO BE COMPLETE BY PARENTS &/OR GUARDIANS

CADET'S NAME:_____
(LAST) (FIRST) (MI)

CADETS DATE OF BIRTH: DAY:_____ MONTH:_____ YEAR:_____

PARENTS/GUARDIANS ADDRESS & PHONE NUMBER(s):

Number & Street_____
City/State/Zip Code_____
Home Phone_____
Cell Phone_____

NEAREST RESPONSIBLE NON-PARENT ADULT WE CAN CONTACT IN CASE OF AN EMERGENCY WHEN YOU ARE NOT AVAILABLE:

NAME:_____
RELATIONSHIP TO CADET:_____
PHONE NUMBER: (HOME)_____
(WORK)_____
(CELL)_____

1. Has your child EVER been advised to have an operation? _____YES _____NO
...if **YES**, Please explain _____
_____
_____

2. Has your child EVER had an injury, illness, or accident requiring medical attention?
_____YES _____NO
...if **YES**, Please explain _____
_____
_____

3. Has your child EVER been a patient in a hospital? _____YES _____NO
...if **YES**, Please explain _____
_____
_____

4. Has your child EVER lived in a group home, a boarding school, or a residential treatment program? _____YES _____NO
...if **YES**, Please explain _____
_____
_____

5. Last dental appointment: _____
Does your child wear braces? _____

6. List any and all previous illnesses **and** injuries: (If **NONE**, state "**NONE**")

_____

_____

_____

7. Last menstrual cycle: _____

8. Last PAP smear: _____

9. List any and all medication(s) your child is currently taking **and** the reason for taking. This includes **both** PRESCRIPTION **and** Over-The-Counter (OTC) medications:
(If **NONE**, state "**NONE**")

_____

_____

_____

_____

10. List any and all MEDICATIONS to which your child is ALLERGIC:
(If **NONE**, state "**NONE**")

_____

_____

_____

11. List any and all ALLERGIES (food, seasonal, insects, etc.) that your child has:
(If **NONE**, state "**NONE**")

_____

_____

_____

12. Does your child wear glasses? _____YES _____NO

NOTE: Contacts are NOT allowed

13. Date of last eye exam: _____

14. Does your child get frequent headaches and/or migraines? _____YES _____NO
...if **YES**, Please explain _____

_____

_____

15. Does your child have a hearing defect? _____YES _____NO
...if **YES**, Please explain _____

_____

_____

_____

PSYCHOLOGICAL HISTORY

Name of Applicant:_____
(LAST) (FIRST) (MI)

1. Are you now or have you ever seen a psychiatrist, psychologist, social worker, counselor or other professional for **ANY** reason? _____**YES** _____**NO**
If **YES**, you must provide written documentation and most recent report.

2. Are you now or have you ever seen a counselor or been treated (inpatient and/or outpatient) for alcohol abuse/problems, drug abuse/problems (to include legal or illegal drugs), substance abuse/problems or any other addiction or addictive behavior?
_____**YES**_____**NO**
If **YES**, you must provide written documentation and most recent report.

3. Are you now or have you ever been evaluated, treated, recommended for treatment, or hospitalized as an inpatient or outpatient for depression, suicidal thoughts or attempts, self mutilation/cutting, violent behavior? _____**YES** _____**NO**
If **YES**, you must provide written documentation and most recent report.

4. Are you now or have you ever been evaluated or treated for sexual or physical abuse?
_____**YES**_____**NO**
If **YES**, you must provide written documentation and most recent report.

5. Are you now or have you ever been evaluated, treated, recommended for treatment, or hospitalized as an inpatient or outpatient for mood or anxiety disorders, hallucinations, paranoia, bipolar disorders? _____**YES** _____**NO**
If **YES**, you must provide written documentation and most recent report.

6. Are you now or have you ever taken medications, drugs, or any other substances to improve your attention, behavior and or physical performance? _____**YES** _____**NO**
If **YES**, please list the names of any and all medications, drugs, substances:

_____
_____
_____

7. Are you now or have you ever taken psychotropic medications in the past two years?
_____**YES** _____**NO**
If **YES**, please list the names of any and all medications, drugs, substances:

_____
_____
_____

FREESTATE CHALLENGE ACADEMY
MARYLAND NATIONAL GUARD
YOUTH CHALLENGE PROGRAM

PART-1: MEDICAL EVALUATION OF STUDENT FOR PARTICIPATION IN THE FREESTATE CHALLENGE ACADEMY

To be completed by Parent or Guardian and submitted to the examining physician before he/she examines student.

Name of Student _____ **Date of Birth** ___/___/___ **ALLERGIES** _____
Last First Middle

Parent _____ **Address** _____ **Home Phone** ( ) -

Personal Health of Student — Check correct reply	YES	NO
1. Has had injuries or accidents requiring medical attention	☐	☐
2. Has had surgical operation	☐	☐
3. Has been in hospital	☐	☐
4. Has had sickness lasting longer than one week	☐	☐
5. Takes medicine now or regularly	☐	☐
6. Has a condition now under a physicians care	☐	☐
7. Has a defect in hearing or eyesight (glasses)	☐	☐
8. Is there any reason this student should not participate?	☐	☐

	YES	NO
9. Has completed poliomyelitis immunization	☐	☐
10. Has had tetanus toxoid and booster	☐	☐
Date of last booster ___/___/___		
11. Has seen dentist within the past 6 months	☐	☐
12. To my knowledge the paired organs that follow are present and healthy		
Ears	☐	☐
Eyes	☐	☐
Lungs	☐	☐
Kidneys	☐	☐
Testicles and Ovaries	☐	☐
Arms/Legs	☐	☐
Fingers/Toes	☐	☐

If you answered "YES" to any of the above questions, explain here with names and dates:

_____

_____

_____

_____

If you answered "NO" to any of the above questions, explain here with names and dates:

_____

_____

I GIVE PERMISSION FOR THE PHYSICIAN TO COMPLETE PART 2 OF THIS FORM FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH AND EDUCATIONAL NEEDS.

_____ _____
PARENT OR GUARDIAN SIGNATURE **DATE**

Revised 07/18/06

FREESTATE CHALLENGE ACADEMY
MARYLAND NATIONAL GUARD
YOUTH CHALLENGE PROGRAM

PART-2: MEDICAL EVALUATION OF STUDENT FOR PARTICIPATION IN THE FREESTATE CHALLENGE ACADEMY
(Must be completed by physician or under his/her supervision)

Name of Student _____
Last First Middle

Significant past illnesses or injuries: _____

PHYSICIANS EXAMINATION: (CIRCLE AND EXPLAIN ABNORMAL FINDINGS)

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Eyes _____ Visual Acuity R ___ / L ___ /

Ears _____ Hearing R ___ / L ___ /

Nose (deformities) _____ Oropharynx _____

Teeth (cavities, dentures, braces) _____ Respiratory _____

Breast (M&F) _____ Cardiovascular (pedal pulse) _____

Abdomen (hernia, spleen, liver) _____ Genitalia and anus _____

Neuromuscular _____ Skin _____

Laboratory (**MANDATORY**)
Urinalysis: Protein _____
Sugar _____
Other _____

Must have
TUBERCULIN TEST
Tuberculin test _____
OR
Chest X-Ray _____
(Results/date)

Spine (cervical, thoracic, lumbar) _____

Extremities (special attention to knees & ankles) _____

Additional explanations of abnormal findings _____

I have on this date **personally** examined this student, reviewed the history and other data recorded on both sides of this form, and find the student physically able to participate in supervised activities listed below.

STRETCHES

Abdominal	Hamstring
Chest	Groin Seated
Upper Back	Groin Standing

EXERCISES

Push-ups	Sit ups
Knee bends	Marching
Road Marching	Side Straddle Hop
Multiple arm Movements	Chin ups

ENVIRONMENTAL FACTORS

Grass/ Trees
Mold
Animals (deer, raccoons, Squirrels, etc.)
Air Quality (such as humid days)

MUST HAVE OFFICE STAMP TO BE VALID

_____ Physicians Signature _____ Date _____ Phone Number

FREESTATE CHALLENGE ACADEMY

Physician's Authorization For

PRESCRIPTION MEDICATION

or

OVER-THE-COUNTER MEDICATION

YOU MAY HAVE TO COPY THIS FORM IF THE PHYSICIAN WRITES FOR MORE THAN ONE MEDICATION FOR STUDENT

CLASS NO_____ FULL NAME OF STUDENT_____

- I understand that I must supply the school with the equipment/supplies needed to administer the medication.
- I understand that all medications must be labeled with the name of the medication, name of student, name of physician, date, and directions for administration. Prescription medication must be labeled by a registered pharmacist.
- I hereby authorize the medication described below to be administered as directed by my child's physician.
- I understand that the physician will be called if a question arises about my child's medication.
- I understand I will be notified when a prescription needs to be refilled and that I must get medication refilled and either bring or send the medication to the medical section in a timely manner.
- 911 will be called immediately in an emergency.

_____ _____

Signature of Parent/Guardian Date

FOR COMPLETION BY PHYSICIAN

NOTE: Per Maryland Law Only One Medication Allowed Per Form

1. Name of medication _____
2. Reason for medication _____
3. Type of device _____
4. Specific direction for use _____
   - Is the student capable of self-administering the medication by device? [ ] Yes [ ] No
   - Should the student carry medication and device with him/her? [ ] Yes [ ] No
5. Dosage of medication _____
6. Time of day medication is to be given _____
7. Date to Begin Medication _____ Date to Discontinue Medication _____
8. Side effects _____

Physicians Signature:_____

Physicians Printed Name & Phone Number:_____

Reviewed By MYC Medical Department:_____

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME _____ LAST _____ FIRST _____ MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE _____/_____/_____

COUNTY _____ SCHOOL _____ GRADE _____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP _____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr
1								
2								
3								
4								
5								

Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1				
2				

Td Mo/Day/Yr	Tdap Mo/Day/Yr	FLU Mo/Day/Yr	Other Mo/Day/Yr

To the best of my knowledge, the vaccines listed above were administered as indicated.

1. _____
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)

2. _____
Signature Title Date

3. _____
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

Clinic / Office Name
Office Address/ Phone Number

LOST OR DESTROYED RECORDS: (Must be reviewed and approved by a medical provider or the local health department. See notes)

I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable.

Signed: _____ Date: _____
Parent or Guardian

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM IMMUNIZATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:
The above child has a valid medical contraindication to being immunized at this time.

This is a ☐ permanent condition ☐ temporary condition until _____/_____/_____

Check appropriate box, indicate vaccine(s) and reasons: _____

Signed: _____ Date _____
Medical Provider / LHD Official

RELIGIOUS OBJECTION:
I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

FREESTATE CHALLENGE ACADEMY
MARYLAND NATIONAL GUARD

Testing and results are required within 45 days of the class start date! No Exceptions!

This is to verify that Cadet _____

Was seen at _____

On _____, for their mandatory Sexually Transmitted Disease

examination. Testing is NOT optional. The following STD screenings must be performed:

Name	Date of Exam
Syphilis	_____
Gonorrhea	_____
Chlamydia	_____
Pregnancy Test	_____

This screening is to ensure that each cadet received proper medical evaluation and is extended any necessary treatment and/or follow-up appointments with a physician.

Physician's signature: _____Date: _____

Attach a copy of the test results to this form. The test results are required for admission into this program.

"No Test Results = No Admission"

FREESTATE CHALLENGE ACADEMY OTC MEDICATIONS

ORAL MEDICATIONS

Tylenol (Non-Aspirin) 325 mg – Give 2 tabs PO every 6 hours as needed for pain, headache, and fever > 100.4

Tylenol Extra Strength (Non-Aspirin Extra Strength) 500 mg – Give 2 tabs PO every 6 hours as needed for severe headache, and pain

Ibuprofen (Motrin/Advil) 200 mg – Give 2 tabs PO every 6 hours as needed for pain/inflammation

Maalox (Alamag) 30 mls – Give 30 mls PO once a day as needed for upset stomach

Tums – Give 2 tabs PO after every meal as needed for indigestion, heartburn, upset stomach

Milk of Magnesia 30 mls – Give 30 mls PO once a day as needed for constipation > 3 days

Benadryl (Diphen) 25 mg – Give 2 tabs PO every 8 hours as needed for anxiety (only if medical diagnosis), insomnia (only if medical diagnosis), and allergic reaction

CCP (Generic Cold Capsules) – Give 2 tabs PO every 8 hours as needed for nasal congestion, chest congestion, seasonal allergies

- Acetaminophen 325 mg (in each tab)
- Guaifenesin 200 mg (in each tab)
- Phenylephrine HCl 5 mg (in each tab)

Diamode 2 mg – Give 2 tabs PO every 8 hours as needed for diarrhea

Loradamed (Similar to Claritin) 10 mg – Give 1 tab PO once a day as needed for upper respiratory allergies

Sore Throat Lozenges (Cepacol) – Give 1 lozenges every 2 hours as needed for pain associated with sore throat

TOPICAL MEDICATIONS

Bacitracin Ointment – Apply BID as needed to cuts/scrapes/abrasions

Hydrocortisone Cream 1% - Apply BID as needed for minor rashes and itching

BioFreeze – Apply BID as needed for minor pains of sore muscles and joints associated with backache, strains, and sprains

First Aid Burn Cream – Apply BID as needed for minor cuts, scrapes, and burns

Medi-First Antifungal Cream – Apply BID as needed for athlete's feet, jock itch, and ringworm

MISCELLANEOUS

Debrox, Earwax Removal Aid – Instill 10 drops into affected ear BID as needed for up to 4 days to help removal of excessive earwax

Eye Wash, Sterile Isotonic Buffered Solution – Instill into affected eye as needed to help flush loose foreign material or chemicals from eye. To help relieve eye irritation, burning, itching or stinging

Opti-Clear Eye Drops – Instill 2 drops into affected eye BID as needed for relief of minor eye irritations

Ayr (Saline Nasal Mist) – Give 2 sprays into each nostril BID as needed for congestion and allergic rhinitis

****

Maryland National Guard _____

Freestate ChalleNGe Academy

PARENTAL AGREEMENT

I/we, the parents/guardians of _____ have reviewed and approved the above listing of over-the-counter medications for use on our child in the event of any minor illness or injury. Any item I/we feel is inappropriate for use will be **crossed out, initialed** and **dated.**

Parent Signature: _____

TAKE THIS FORM TO THE SAME PHYSICAIN WHO PERFORMED THE CADETS PHYSICAL EXAMINATION. PHYSICIANS SIGNATURE IS REQUIRED.

PHYSICIAN CONCURRENCE

I have reviewed and approved the above listing of over-the-counter medications for use on cadet _____ in the event of any minor illness or injury. Any item I feel is inappropriate for use will be **crossed out, initialed** and **dated.**

PRINTED NAME OF PHYSICIAN: _____

PHYSICIANS SIGNATURE: _____

****RETURN THIS COMPLETE PACKAGE TO THE MEDICAL SECTION at FREESTATE CHALLENGE ACADEMY****