TEXAS CHALLENGE ACADEMY
APPLICATION PACKET

RECLAIMING THE POTENTIAL OF AT-RISK YOUTH THROUGH EDUCATION, TRAINING, MENTORING AND SERVICE TO THE COMMUNITY.

A Youth Education Program of the Texas National Guard

Texas ChalleNGe Academy
ATTN: Admissions
600 HWY 3013 West
Eagle Lake, Texas 77434
1-877-822-0050 (Toll Free)
https://www.texaschallengeacademy.com
Admissions Department: tca_admissions@tmd.texas.gov

Applicant Information (PLEASE PRINT)		
Last Name:	First Name:	Middle:
DOB:(mm/dd/yy)	SSN:	Male: ☐ Female: ☐
Street:	City:	
County:	State:	Zip Code:
Parent's Cell Phone:	Additional Phone:	
Parent's Home Phone:	Parent's Email:	
Preferred Contact Method: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email		
Ethnicity: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black (Not of Hispanic Origin) ☐ Hispanic or Latino ☐ Caucasian ☐ Native Hawaiian or Pacific ☐ Multiracial ☐ Other		
Parent/Legal Guardian Name:		
Parent/Legal Guardian Address (if different from applicant's):		
TCA Recruiter Name:	How Did You Hear About TCA:	

Eligibility Requirements		
Yes	No	Will you be 16-18 years old when the class starts? You must be 16 years old to apply to TCA and must be 18 years old or younger on the first day of the program.
Yes	No	Are you a US citizen or a legal resident of the United States and a resident if Texas?
Yes	No	Have you ever been convicted of a felony: **If answered yes, not eligible to apply.**
Yes	No	Do you have a high school diploma or a GED? Current # Credit Hours: _____
Yes	No	Are you currently employed? If yes, please answer the following: Number of hours/week _____ Hourly wage: _____
Yes	No	Are you willing to be free from the use of illegal drugs/alcohol and/or illegal substances during the program? **TCA is not a drug/alcohol or substance abuse rehabilitation program.**
Yes	No	Are you willing to participate in a progressive physical training program (i.e. running, push-ups, sit-ups, pull-ups, warm-up exercises)?
Yes	No	Have you been detained, ticketed or arrested for any offense by any law enforcement Agency? **If you answered yes, you must bring all court documents and any probation information to the screening.**
Yes	No	Are you awaiting sentencing or have future court dates to resolve pending charges? **All charges must be resolved before the first day of class.**
Yes	No	Have you been discharged from a treatment facility for mental health, substance abuse or behavior in the past 6 months? **Because of the residential nature of our program, 6 months of stability at home is required prior to attending.**
Yes	No	Have you been discharged from a treatment facility for mental health, substance abuse or behavior more than 6 months ago? **If you answered yes, you must bring copies of the discharge summaries to the screening.**
Yes	No	Have you had periods of depression, attempted suicide, or seriously considered suicide? **TCA is not a therapeutic counseling program or mental health treatment facility.**
Yes	No	Do you currently have an Individualized Education Plan (IEP), Full Individual Evaluation (FIE) or 504 plan at your High School? **If you answered yes, you must bring copies of the documents to the screening.**

I certify that all information provided is true and accurate to the best of my knowledge and understand that any false or omitted information will be grounds for not being accepted or for dismissal.

Applicant Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

Texas Challenge Academy Application Checklist

Required Documents (at screening)

- ☐ Cadet Application, Medical Screening Forms/Sports Physical Form (Pages 1-11)

Provide copies of the following:

- ☐ Copy of US Birth Certificate or INS Proof of Permanent Residency Card (I-551)
- ☐ Copy of Unofficial School Transcripts from Last School Attended (not a report card)
- ☐ Copy of Immunization Record

Required Documents if applicable (use N/A if these items do not apply to you)

- ☐ Copy of Arrest Record/Court Documents/Probation Information for all resolved or pending offenses
- ☐ Copy of Discharge Summaries for In-Patient Treatment for Substance Abuse, Mental Health or Behavior
- ☐ Copy of the Current Individual Education Plan (IEP)/FIE or 504 Plan

Additional Required Documents (before acceptance)

- ☐ Eye Exam – within 12 months of class start date
- ☐ Dental Exam – within 12 months of class start date
- ☐ Copy of Social Security card
- ☐ Copy of TX State Identification Card/Driver's License, Military ID or Passport (not a student ID)
- ☐ Copy of Front and Back of Medical Insurance Card (applicants are required to have medical insurance)
- ☐ TB Test within one year of class start date (required by Texas for residential programs)
- ☐ School disciplinary records - due to suspension/expulsion/DAEP attendance (if requested)
- ☐ Complete Mentor Packet (8 pages)

Additional Contact Information

Last Name:		First Name:
Street:		Home Phone:
City		Cell Phone:
State:	Zip Code:	Email:

Relationship: ☐ Parent ☐ Legal Guardian ☐ Step Parent ☐ Grand Parent Other:_____

Last Name:		First Name:
Street:		Home Phone:
City		Cell Phone:
State:	Zip Code:	Email:

Relationship: ☐ Parent ☐ Legal Guardian ☐ Step Parent ☐ Grand Parent Other:_____

Authorization to Release Confidential Information

PURPOSE: In processing your application, there may be a need to confirm or clarify personal information you provide with an outside agency. This form authorizes us to contact those agencies and exchange information necessary to properly review and evaluate your application.

Applicant Name:_____ Birth Date: _____

Current County Applicant Lives: _____

Other Texas Counties Applicant has Lived:_____

I hereby authorize the State of Texas, its counties, its cities, and its agencies to submit and/or exchange all pertinent information with the Texas ChalleNGe Academy (TCA) regarding, but not limited to, the following: substance abuse history, referral history, court status, family or social services interventions, documented medical conditions, and any other information requested by the TCA relevant to the health, safety, welfare, and quality of life of the student/applicant named above.

I understand that these records are protected under the federal or state confidentiality laws or regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. TCA is in compliance with the most prominent of the federal protections for participant privacy including the Family Educational Rights and Privacy Act (FERPA), also known as the "Buckley Amendment." FERPA protects the confidentiality of student record to some extent while giving students the right to review their own records.

I also understand that I may revoke this consent at any time except to the extent that action has been taken and that in any event this consent automatically expires thirty -six (36) months from the date my application is accepted and I am officially registered as a student in the TCA.

Applicant Signature:	Date:
Parent/Legal Guardian Signature:	Date:

Authorization for Criminal Background Check

DATA REQUIRED BY PRIVACY ACT OF 1974

PRINCIPLE PURPOSE: To determine eligibility for admission to the Texas ChalleNGe Academy.

DISCLOSURE: Disclosure is voluntary, however, failure to supply any required information may result in your being refused admission in the Texas ChalleNGe Academy. The data obtained is for OFFICIAL USE ONLY and will be maintained and used in strict confidence in accordance with applicable law and regulations. Making a knowing and willful false statement on this form may automatically prevent your acceptance to or be grounds for dismissal from the Texas ChalleNGe Academy.

I,_____, a potential applicant to the Texas ChalleNGe Academy, do hereby consent to a criminal background check conducted by TCA Staff.

Applicant Signature:	Date:
Parent/Legal Guardian Signature:	Date:

Consent for Medical Care

Student Information	
Last Name:	First Name:
Street:	City
State	Zip Code

It is further understood that Texas ChalleNGe Academy carries medical insurance for accidental injuries only. Medical care outside the scope of Texas ChalleNGe Academy Medical Staff will be the financial responsibility of the parent or legal guardian. The Medical Staff will determine the need for my son/daughter to be seen by a physician if necessary. My insurance information is listed below:

Medical Insurance Company: _____ Phone # for Certification: _____

Policy Holder's Name: _____ Policy or Group #: _____

Medicaid or CHIPS #: _____ Parent Work Phone: _____

Parent Email Address: _____ Parent Cell Phone _____

Applicant Signature:	Date:
Parent/Legal Guardian Signature:	Date:

Emergency Contact Information in the Event Parent or Guardian Cannot be Reached

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

I have read and understand all of the above and to the best of my knowledge, the information supplied is correct.

_____

Parent/Legal Guardian Signature:

TCA Medical Screening Forms

PLEASE COMPLETE PAGES 6, 7 & 8

The Texas ChalleNGe Academy training is physically demanding. Physical training may include strenuous activities such as:

1. A daily run of one or more miles on a hilly course.
2. Daily vigorous exercises such as push-ups, pull-ups, sit-ups and other calisthenics.
3. An obstacle course.

These screening forms are used in determining the applicant's fitness to engage in strenuous activities as outlined above. A physical exam must be performed with **twelve (12) months** of the first day of the class start date. A high school sports physical completed with 12-months of the class start date is satisfactory.

FILL OUT THE FORM COMPLETELY AND ACCURACTELY. EVERY LINE MUST BE COMPLETED. IF A QUESTION IS NOT APPLICABLE (USE N/A)

Any questions concerning this examination or the applicant's ability to participate may be directed to TCA Staff at 877-822-0050. All applicants must also have vision and dental exams completed prior to acceptance.

Last Name (Applicant): _____ **First Name:** _____

Are you currently using any **prescribed** medications? ☐ YES ☐ NO
If yes, please list all medications.

Medication:	Why Taking	How Long?

Last Name (Applicant): _____ First Name: _____

Are you allergic to any medications, foods or other agents such a bee stings, wool etc.? ☐ YES ☐ NO
If yes, please list the agent and the reaction.

Allergen	Reaction	Treatment

Have you ever been admitted to a hospital for substance abuse, mental health or behavior? ☐ YES ☐ NO
If yes, please list the date, hospital and reason for treatment.
You must also provide a discharge summary for each case of inpatient care.

Month/Year	Hospital	Treatment

Have you ever been treated for:

☐ ADHD ☐ Bipolar Disorder ☐ Depression ☐ Conduct Disorder ☐ ODD ☐ Obsessive Compulsive Disorder

Suicide Attempt(s)? ☐ YES ☐ NO If yes, date: _____

Rehab for Drug or Alcohol Abuse: ☐ YES ☐ NO If yes, date: _____

Have you ever used? ☐ Marijuana ☐ Crack

☐ Cocaine ☐ Heroin ☐ Spice/K2 ☐ Xanax ☐ Ecstasy ☐ Meth ☐ Other

Alcohol of Choice ☐ Beer ☐ Wine ☐ Liquor

Do you smoke or use tobacco products? ☐ YES ☐ NO How Often? _____

Last Name (Applicant): _____ **First Name:** _____

Do you have or have you ever been treated for any of the following:

	NO	YES			NO	YES	
1.			Headaches, Migraines or Clusters	23.			Diabetes/Hypoglycemia
2.			Severe Head Injuries	24.			Thyroid Problems
3.			Loss of Consciousness	25.			Kidney/Urinary Problems
4.			Seizures/Convulsions	26.			Intestinal Problems
5.			Heart Disease/Murmurs/Irregular HB	27.			Bedwetting (since age 14)
6.			Chest Pain	28.			Severe Acne
7.			High Blood Pressure	29.			Frequent Stomach aches/Ulcers/Reflux
8.			Circulation Problems	30.			Staph Infection
9.			Anemia/Sickle Cell/Blood Disorder	31.			Athletes Feet/Skin Fungus
10.			Unexplained Sweating	32.			Cold/Heat Intolerance
11.			Dizziness/Fainting Spells	33.			Allergies
12.			Neck and/or Back Problems	34.			Tuberculosis/Positive TB Test
13.			Scoliosis	35.			Depression/ADHD/Bipolar
14.			Muscle Cramps	36.			Mental Illness/Psychological Disorder
15.			Pins/Screws/Rods	37.			Hearing Impairment
16.			Flat Feet	38.			Communicable Diseases
17.			Broken Bones	39.			Adverse Reaction to Drugs
18.			Arm/Shoulder Problems				**FEMALES ONLY:**
19.			Hip/Knee/Ankle/Foot Problems	40.			Heavy or Difficult Menstrual Cycle
20.			Wheezing/Asthma/Shortness of breath	41.			Untreated Abnormal Vaginal Discharge
21.			Anorexia/Bulimia	42.			Are you Pregnant?
22.			Hepatitis/Liver Problems				

All yes responses must be explained by number. You may use the back of this page if necessary.

_____

_____

_____

_____

_____

_____

_____

_____

_____

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

2017

This **MEDICAL HISTORY FORM** must be completed ***annually*** by parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

Student's Name: (print) _____ Sex _____ Age _____ Date of Birth

Address _____ Phone _____

Grade _____ School _____

Personal Physician _____ Phone _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain "Yes" answers in the box below**. Circle questions you don't know the answers to.

	Yes	No
1. Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
2. Have you been hospitalized overnight in the past year?	☐	☐
Have you ever had surgery?	☐	☐
3. Have you ever had prior testing for the heart ordered by a physician?	☐	☐
Have you ever passed out during or after exercise?	☐	☐
Have you ever had chest pain during or after exercise?	☐	☐
Do you get tired more quickly than your friends do during exercise?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Have you had high blood pressure or high cholesterol?	☐	☐
Have you ever been told you have a heart murmur?	☐	☐
Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	☐	☐
Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?	☐	☐
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
4. Have you ever had a head injury or concussion?	☐	☐
Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
If yes, how many times? _____		
When was your last concussion? _____		
How severe was each one? (Explain below)		
Have you ever had a seizure?	☐	☐
Do you have frequent or severe headaches?	☐	☐
Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
Have you ever had a stinger, burner, or pinched nerve?	☐	☐
5. Are you missing any paired organs?	☐	☐
6. Are you under a doctor's care?	☐	☐
7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	☐	☐
8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
9. Have you ever been dizzy during or after exercise?	☐	☐
10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
11. Have you ever become ill from exercising in the heat?	☐	☐
12. Have you had any problems with your eyes or vision?	☐	☐

	Yes	No
13. Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
Do you have asthma?	☐	☐
Do you have seasonal allergies that require medical treatment?	☐	☐
14. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
15. Have you ever had a sprain, strain, or swelling after injury?	☐	☐
Have you broken or fractured any bones or dislocated any joints?	☐	☐
Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐

If yes, check appropriate box and explain below:

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/Calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper Arm	☐ Foot	

16. Do you want to weigh more or less than you do now?	☐	☐
17. Do you feel stressed out?	☐	☐
18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	☐	☐

Females Only

19. When was your first menstrual period? _____
When was your most recent menstrual period? _____
How much time do you usually have from the start of one period to the start of another? _____
How many periods have you had in the last year? _____
What was the longest time between periods in the last year? _____

Males Only

20. Do you have two testicles? _____
21. Do you have any testicular swelling or masses? _____

An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question three above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.

**EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):

_____
_____
_____
_____

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the school assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL

Student Signature: _____ Parent/Guardian Signature: _____ Date: _____

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Student's Name _____ Sex _____ Age _____ Date of Birth _____ Height _____ Weight_____ % Body fat (optional) _____ Pulse _____ BP____/____ (____/____, ____/____)

brachial blood pressure while sitting

Vision: R 20/_____ L 20/___ Corrected: ☐☐ Y ☐☐ N Pupils: ☐☐ Equal ☐☐ Unequal

As a minimum requirement, this **Physical Examination Form** must be completed prior to junior high athletic participation and again prior to first and third years of high school athletic participation. It ***must*** be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side. **** Local district policy may require an annual physical exam.***

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position			
Heart-Auscultation of the heart in the standing position			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			

MUSCULOSKELETAL

Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

CLEARANCE

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: _____

_____

☐ Not cleared for:_____Reason: _____

Recommendations: _____

_____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.

Name (print/type) _____ Date of Examination: _____

Address: _____

Phone Number: _____

Signature: _____

Mentor Information

Position Summary: The Mentor serves as a role model, friend and advocate to a Cadet for 17 ½ months.

Working Relationships: Reports to Case Manager (CM) or RPM Coordinator. Mentors only one Cadet.

Duties and Responsibilities:

- Mentor returns completed screening materials.
- Completes Mentor Training at TCA campus or other designated location.
- During the Residential Phase, Mentor commits to having at least four hours of visitation with the youth either on campus (by appointment) or while at home on P-RAP pass.
- Commits to spending 17 ½ months in consistent contact with Cadet.
- Assists the Cadet with the Post Residential Action Plan (P-RAP) modification and discusses his or her progress in that plan monthly.
- During the Post-Residential Phase, Mentors must make weekly contacts with the Cadets by phone, mail, email, or in person. Four to six hours of contact per month are required. At least one of these must be face-to-face during the Post-Residential Phase.
- Shares occasional, informal and fun activities with his or her Cadet. The Mentor and Cadet will jointly select and schedule the activities.
- Communicates at least monthly by phone, mail or email with the CM or RPM Coordinator. The Mentor promptly informs the CM of problems or needs in the Cadet's life or in their relationship.
- Observes all Program policies and guidelines for Mentors. Discusses violations of policies by Cadets with a Case Manager.
- Refers the Cadet to community resources as needed and helps the Cadet find and research those resources.

Mentor Contact Information

Last Name:	First Name:
Age:	Gender:
Home Address Street:	City:
State:	Zip Code:
Cell Phone:	Work Phone:
Email Address:	Profession/Trade: