ALASKA MILITARY YOUTH ACADEMY

Medical Packet Checklist

2

PRIOR TO COMPLETING THIS PACKET YOU SHOULD HAVE:

- **COMPLETED APPLICATION PACKET (1)**
- **PARTICIPATED IN INTERVIEW WITH ADMISSIONS REPRESENTATIVE**

THE MEDICAL PACKET MUST BE SUBMITTED ASAP
IF THIS PACKET IS NOT SUBMITTED, THE YOUTH CANNOT ATTEND

☐ **Alaska Power of Attorney (M2)** ******Must be Notarized*******

DO NOT SIGN BEFORE BEING IN THE PRESENCE OF A NOTARY

*****Rural Villages that do not have notaries may use the local postmaster pursuant to AS 44.50.180. ****

☐ **Authorization to Administer Over-the-Counter (OTC) Medications (M3)**

☐ **Medical Consent for Release of Information (M4)**

☐ **Medical Care Authorization & Insurance Information (M5).**

☐ **Understanding of Limited Medical Services (M6)** *May want to review with HC Provider*

☐ ***Medical History-** Please complete this form prior to completing the physical and review this form with your Medical Professional while at the Physical Examination Appointment. **(M7-9)**

☐ ***Prescription Medications & Allergies (M10)** *May want to review with HC Provider*

☐ ***Physical Examination Form (M11)** ***Health Care Provider must complete within 6 months of the start of the cycle.*** Please have Provider read back-Information for Health Care Provider. If you are unable to obtain due to lack of medical facilities, cost, or other reason please indicate this on the form and notify your admissions representative ASAP.

☐ *Medical Statement to Request Special Meals and/or Accommodations- **ONLY REQUIRED IF youth has food allergies. (M12)**

***Conditional Acceptances may be rescinded due to findings in the Medical Packet.**

One of the goals of the Alaska Military Youth Academy is to care for the physical and mental health of your cadet while in residence. This job begins prior to admission by ensuring all cadets are ready and prepared for their stay with us.

- If outside appointments are necessary during the residential period, the Nursing Staff will arrange times and transportation. If the parents live locally, the Nursing Staff may ask the parent to transport the cadet (for those in the Anchorage/Matsu area). No appointments should be made by parents for your cadet while in attendance without making prior arrangements with the Nursing Staff. The nursing staff can assist parents in minimizing the effect outside appointments have on planned AMYA activities including classes, testing, and other scheduled training. NO appointments are made within the first two weeks of the program unless specifically allowed by AMYA medical.
- Copy of any current eyewear prescription (within 1 yr.) should be provided with packet. **Applicants will need 2 pairs of glasses upon arrival at AMYA. Contact lenses are not permitted.**
- Medications are administered by the registered nurse or an authorized person for your cadet. If possible, medication prescriptions need to be supplied for the 5-month duration. Applicants are required to have at least a 30-day supply of needed medications and two months of refills (prescriptions). Medications to bring include any that your cadet is currently prescribed including asthma inhalers and EpiPens.
- For questions regarding prescriptions for controlled medications, please contact 907-428-7364. The preferred pharmacy for use is; The Family Pharmacy located at 11432 Business Blvd #10, Eagle River, AK 99577, phone number (907) 694-7007.

This packet can be faxed 907-428-7385, scanned to goamya@alaska.gov or your assigned admissions representative, or submitted directly to an AMYA Admissions Office.

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Military and Veterans Affairs
Alaska Military Youth Academy
P.O. Box 5727
JBER, AK 99505-0727

POWER OF ATTORNEY

I, X _____, herby grant to the Alaska Military Youth Academy (a division of the Alaska
Parent/Guardian Name or Applicant if 18
Department of Military &Veteran's Affairs) any powers that I may have regarding care, custody, and control of the person of X _____, (hereinafter "the minor") except to marriage or adoption.
Applicant's Name

This power is granted pursuant to Alaska Statute 13.26.020.

Specifically included within this Power of Attorney is the grant of authority to the Alaska Military Youth Academy to consent to medical and dental procedures on behalf of the minor, in the situation where neither I nor any other parent or legal guardian of the minor can be contacted within a reasonable time, or the situation where neither I nor any other parent or legal guardian is able make medical and dental decisions or consent to medical and dental procedures on behalf of the minor.

Also specifically included within this Power of Attorney is the grant of authority to the Alaska Military Youth Academy the power to request, review, and receive any information, verbal or written, regarding the minor's physical or mental health, including, but not limited to, medical, dental, hospital and school records, and to execute on my behalf any releases or other documents that may be required in order to obtain this information.

The power given herein is granted to insure the safety and well being of the minor and shall be effective for the period of time that the minor is enrolled in the residential phase of the Alaska Military Youth Academy's ChalleNGe Program. Should the minor be dis-enrolled from the Military Youth Academy for any reason, this power of attorney shall terminate immediately.

The Power granted herein shall be exercised only by the Director, Deputy Director, Commandant of Cadets, or Principal of the Alaska Military Youth Academy. In no event shall this power of attorney extend for a period greater that 24 months from the date that I sign this document or completion of the residential portion of the program, whichever comes first. Nothing herein shall mean that I relinquish any legal right to custody of the minor but gives Attorney in Fact authority to act on my behalf.

(1) Parent Printed Name (or applicant if 18):_____

Address: _____

(1) Parent Signature (or applicant if 18) *_____*

(*sign in the presence of a legalized notary public*) *Rural Villages that do not have notaries may use the local postmaster pursuant to AS 44.50.180*

NOTARIZATION: Signed and sworn to this _____ day of _____month in the _____ year

In the State of _____, _____Judicial District

Known to me or satisfactorily proven to be the person(s) whose name is subscribed to this instrument and acknowledge that he/she/they executed the same. If this/these person(s)' name (s) is/are subscribed in a representative capacity, it is for the principle named in the capacity indicated.

Name of Notary Official: _____

Signature: _____

Commission Expires: _____

PURPOSE: Both the parent/guardian and applicant must read and sign the form indicating their agreement and acceptance of the terms and conditions outlined below.

AUTHORIZATION TO ADMINISTER OVER-THE-COUNTER MEDICATIONS

APPLICANTS NAME: _____ _____ _____
Last First Middle

LIST OF OVER-THE-COUNTER MEDICATIONS THAT MAY BE USED:

Health Complaint	Examples of Medications Used
Allergies	Benadryl, Claritin, Allegra, Zyrtec
Athlete's Foot	Lotrimin, Anti-fungal creams
Bee Sting	Hydrocortisone cream, Benadryl
Cold, cough, sore throat	Mucinex, Mucinex DM, Cough Drops
Constipation	Milk of Magnesia, Colace, Miralax
Cramps	Ibuprofen, Tylenol
Cuts, Scrapes, Lacerations	Hydrogen Peroxide, Betadine, Bacitracin, Triple antibiotic ointment
Diarrhea	Imodium, Bismuth subsalicylate, Alkalak
Ear care	Debrox, Hydrogen Peroxide
Eye irritation	Artificial tears, Visine, Saline
Ingrown toenail	Epsom salt soak
Irritated skin, Bug bites	Aloe, Hydrocortisone cream, Calamine Lotion
Lice treatment	RID lice killing shampoo
Minor burns, Sunburn	Aloe, Sunscreen lotion
Pain, Fever, Headache	Tylenol, Ibuprofen
Upset stomach, Heartburn	TUMS Antacid, Bismuth subsalicylate

I do not want the following over the counter medications (OTC) to be given to my child or ward, and AMYA is not authorized to give the following over-the-counter medications to my child:

_____

_____

SIGNATURES:

I authorize the AMYA staff to give certain over-the-counter medications (per label instructions) for the treatment of minor injuries and illnesses (list above). Before giving medications, the nurse checks medical history, allergies, and any other medications your child is taking to make sure there is no conflict.

_____	_____	_____
(1) Parent/Guardian PRINTED Name *(Parent/Guardian not required if applicant is 18)*	Parent/Guardian SIGNATURE	Date
_____	_____	_____
(A) Applicant PRINTED Name	Applicant SIGNATURE	Date

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Military and Veterans Affairs
Alaska Military Youth Academy
P.O. Box 5727
JBER, AK 99505-0727

Medical Consent for Release of Information

Name of Youth whose information is to be released (last, first, MI):	Date of Birth:	Medical Record # or SS# or Student ID#

I authorize this release of information to: Alaska Military Youth Academy Medical Section
PO Box 5727 JBER, AK 99505 | Phone: 907-428-7364 |Fax: 907-428-7386

Authorization includes: Medical Services, Dental, Optometry, Home-Based Services, Behavioral Health and Alcohol/Substance Abuse Treatment all of which may include: Laboratory/Radiology Reports, History/Physical Examinations, Immunizations Records, Discharge Summary, Medication Lists, HIV/AIDS/Transmittable Diseases, Sexual Assault Information, Assessment, Mental Health, Treatment Plan, Medication Management Notes, Alcohol/Drug Treatment

Information to be released: ☐ ALL ☐Only information pertaining to: _____
_____
_____

The Purpose of the release is to: **Determine is the youth meets program eligibility and/or Coordination of Care/Medication Management**

Duration of Authorization: This written authorization will remain valid for 2 years from the date of signature or from graduation from the Alaska Military Youth Academy, which ever comes first.

I understand that:

- Those medical facilities releasing information will not condition treatment, payment, enrollment or eligibility for benefits or services if I refuse to sign this form.
- I understand that the information in my health record may include records relating to sexually transmitted diseases, drug and/or alcohol abuse treatment which may include sensitive information that is covered under 42 CFR part 2, and psychiatric care or other sensitive information.
- I may inspect and receive a copy of this release of information form upon my request;
- I may revoke this release of information at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- I understand the receiver of the release of information will not release any medical information to any other person/organization unless required by a court order.
- If I am requesting records of a minor child or an incapacitated adult, I must sign this form and include my relationship and authority to sign on their behalf.
- I understand a photo copy or fax of this form is as valid as the original.

Signature of Requestor (youth is 18 or older, parent/guardian if youth is under 18)	*Date Signed*
Printed Name of Requestor-youth if 18 or over	*Relationship to Youth: (ie self if 18+, or parent/guardian)*

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Military and Veterans Affairs
Alaska Military Youth Academy
P.O. Box 5727
JBER, AK 99505-0727

Medical Care Authorization & Insurance Information

I/We understand that my/our child/ward *(or self if age of legal consent)* (A)_____
(applicant's name)
will be provided limited medical care during his/her participation at the Alaska Military Youth Academy.

I/We therefore consent, in advance, to allow whatever emergency medical treatment is considered necessary by attending medical staff in the event my/our child/ward suffers illness or injury during his/her participation at the Academy.

I/We understand that every reasonable effort will be made to notify me/us of illness or injury to my/our child/ward. I/We understand and agree that any necessary medical treatment will not depend upon such notifications.

Parent/Guardian/Or Self if 18, please select one of the following statements:

_____I/we **DO NOT** currently possess medical treatment rights or medical insurance to cover costs incurred for medical treatment for my/our child/ward. Understand you will be billed for any medical needs.

_____I/we currently possess medical rights and /or insurance under which my/our child/ward is covered. Examples of rights/ insurance include, but are not limited to active duty military dependent, Medicaid, Indian Health Service access, private or group health insurance plans.

My/our Health right/insurance provider/agency's name:_____

Please provide proof of insurance.
Copies of insurance cards are acceptable OR complete policy information below:

Persons name policy is in:_____; Group #_____,

Policy #_____, Member #_____, BIA #_____ ,

Medicaid #_____ Expiration date of the policy:_____

Co-pay amount _____

Coverage type (check all that applies): Full Medical ____ Dental ____ Vision ____ Prescriptions ____

Insurance Co. address: _____

Insurance Co. Ph #: _____ Date of Birth of policy holder_____

SSN # of policy holder:_____ Employer:_____

_____ _____ _____

(1) Parent/Guardian PRINTED Name *(Applicant may complete if age 18)* | Parent/Guardian SIGNATURE *(Applicant may complete if age 18)* | Date

UNDERSTANDING OF LIMITED MEDICAL SERVICES

PURPOSE: This form outlines the medical conditions that might prevent entrance or continued enrollment into AMYA. It explains the policies and procedures that govern how medications and medical services are provided to the Youth.

OVERVIEW:

AMYA has very limited medical services available to the cadet. AMYA employs a full time Registered Nurse(s) that is available for minor illnesses and injuries. We are unable to provide and do not have the resources to transport Cadets to any "on going" treatment or care. We are unable to accept applicants who will require on-going medical, dental care, mental health, behavioral or counseling services/care. **Parents/legal guardians are to take care of all medical, dental, and vision matters that will prevent program participation prior to registration.** **All medical conditions must be disclosed at time of application.** If it is learned after the applicant arrives at AMYA that serious medical conditions exist, the cadet **may** be dismissed from the program and sent home. AMYA will not accept responsibility, financial for personal liability, or risk for previous medical, physical, or mental histories that limit participation in the program. Applicants should have a physical examination completed by a licensed medial provider within six months from the start date of the class for which applying for, exams within 12 months may be accepted if unable to update due to cost/location. All injuries and dental/medical/vision conditions must be resolved, and the applicant free from additional required care, prior to entrance into the program.

The following conditions may prevent entrance into AMYA:

- Extensive use of multiple medications necessary to treat multiple conditions on a daily basis.
- Current or previous injuries/surgeries that prevent full participation in all AMYA activities.
- Dental services: broken teeth, cavities, abscess and mouth disorders that impact/prevent the ability of the applicant to participate without on-site care or assistance.
- Conditions or medications that adversely react or have side effects impacted by the high intensity physical activity and seasonal weather conditions that compromise the safety, health, and welfare of the cadet. Medications/conditions that may react adversely to extreme summer heat and winter cold.
- Historic or current conditions requiring medical, psychological or psychotic intervention for suicide treatment, manic depression, anxiety, etc. Mental health services are not available from AMYA.
- Extensive dietary restrictions medically required by a medical physician.

AMYA medications/medical care policy:

- All required prescription medications must be disclosed in advance during the application process.
- All potential side effects and limitations of required medications must be disclosed at time of application.
- A medical release, approval and signature must be provided by the doctor in advance stating: Applicant can safely participate in extreme hot and cold conditions while consuming required prescription/medication(s).
- Parents/guardians are entirely responsible for all prescription medications and re-fills during the program.
- Parents/guardians are responsible for all required medical/dental/psychological care before, during, and after participation in AMYA.
- Injuries/physical/medical changes or new medications, required by the applicant after the initial physical examination, must be disclosed in writing prior to entry into AMYA for purposes of review, safety, health, and welfare.
- Cadets with dental or medical needs that require ongoing "emergency" care, offsite time away from the program for 5 days, or that prevent participation will be dismissed and sent home.
- Medical/dental/vision care that does not hinder participation is to occur during AMYA scheduled breaks or at completion of the residential phase.

SIGNATURES:

I understand and agree that I am responsible for all medical/dental/mental health care of my child during, before and after participation in AMYA. By my signature below, I acknowledge that I have read and understand the above medical information.

_____	_____	_____
(1) Parent/Guardian PRINTED Name	Parent/Guardian SIGNATURE	Date
(Parent/Guardian not required if applicant is 18)		
_____	_____	_____
(A) Applicant PRINTED Name	Applicant SIGNATURE	Date

PURPOSE: The following information must be filled in and signed in order for the youth to participate in AMYA. Understandably, youth will need to be able to withstand the physical and emotional stressors. These questions are designed to determine if the youth has developed any condition which would prove harmful for them to participate at AMYA. "Yes" answers are not necessarily disqualifiers. Dishonesty or non-disclosure of medical history are disqualifiers.

MEDICAL HISTORY

Applicants Name: _____ **Date of Birth:** ____/____/___

Parent / Legal Guardian: _____

Primary Care Physician: _____ **Physician Phone #:** _____

DO YOU HAVE OR HAVE YOU EVER HAD?	No	Yes	IF YES, EXPLAIN:
1 Asthma	☐	☐	
2 Sinusitis or hay fever	☐	☐	
3 Epilepsy or seizures	☐	☐	*Seizure disorder should be medically stabilized.*
4 Wear corrective lenses	☐	☐	
5 Lack of vision in either eye	☐	☐	
6 Hearing loss	☐	☐	
7 Food allergies	☐	☐	
8 Medication allergies	☐	☐	
9 Nose bleeds	☐	☐	
10 Shortness of breath	☐	☐	
11 Palpation or pounding heart	☐	☐	
12 High or low blood pressure	☐	☐	
13 Eating disorder	☐	☐	
14 Frequent sore throats	☐	☐	
15 Recurrent ear infections	☐	☐	
16 Frequent or severe headaches	☐	☐	
17 Dizziness or fainting spells	☐	☐	
18 Head injury	☐	☐	
19 Nerve injury	☐	☐	
20 Tonsils removed	☐	☐	
21 Jaundice or hepatitis	☐	☐	
22 Broken bones	☐	☐	
23 Skin disease	☐	☐	
24 Organ loss	☐	☐	
25 Hernia	☐	☐	
26 Periods of unconsciousness	☐	☐	
27 Recent gain / loss in weight	☐	☐	
28 Wear a brace or back support	☐	☐	
29 Swollen or painful joints	☐	☐	
30 Arthritis, rheumatism, or bursitis	☐	☐	
31 Frequent or painful urination	☐	☐	

DO YOU HAVE OR HAVE YOU EVER HAD?	No	Yes	IF YES, EXPLAIN:
32 Recurrent back pain or any back injury	☐	☐	
33 Trick or locked knee	☐	☐	
34 Foot trouble	☐	☐	
35 Bed wetting since age 12	☐	☐	
36 Household contact with anyone who has tuberculosis	☐	☐	
37 Tuberculosis or positive TB test	☐	☐	
38 Have you ever been sexually active	☐	☐	
39 STD / Syphilis / Gonorrhea, etc.	☐	☐	
40 Have you ever been diagnosed with a learning disability?	☐	☐	
41 Used illegal substance / Use tobacco	☐	☐	
42 Sleep walking	☐	☐	
43 Have you been a patient in any type of hospital?	☐	☐	
44 Have you had, or have you been advised to have any operations?	☐	☐	
45 Have you ever had any illness or injury other than those already noted?	☐	☐	
46 Have you ever been diagnosed with ADHD/ADD?	☐	☐	

* May require additional information/documentation to determine is AMYA is suitable placement.

47 Diabetes or hypoglycemia*	☐	☐	
48 Heart trouble*	☐	☐	
49 Pain or pressure in chest*	☐	☐	
50 Bone, joint, or other deformity*	☐	☐	
51 Suicide attempt or plans*	☐	☐	
52 Ever been treated for mental health condition? * (this excludes ADHD/ADD)	☐	☐	
53 Chronic depression*	☐	☐	

Please list all Mental Health Diagnosis:

_____

Please list all treatment programs the youth has attended, dates of attendance, and outcome (ie completion, Left against medical advice, etc):

_____

_____

_____

_____

FEMALES ONLY:

54 Treated For a female disorder ☐ ☐ _____

55 Change in menstrual pattern ☐ ☐ _____

56 Do you take any birth control? ☐ ☐ _____

57 Date of last menstrual period: ___/___/___

Please ensure you have not left any question unanswered (circle those questions you don't know the answers to in order to indicate that you have read them). Include explanations and/or back of this page for all those questions marked, "Yes." Explanations should include any of the following format that is applicable: "Date from – Date to, explanation or cause of illness or injury, treatment, or medication received/completed, outcome/result, etc." You may add additional information/explanation below:

Additional Information/Explanation: _____

_____

_____

_____

I affirm that the Medical History provided is completed and accurate to the best of my knowledge. Any changes in medical history must be provided to AMYA as soon as possible. Changes in medical status may change eligibility.

Failure to disclose information could be reason for denial.

_____	_____	_____
(1) Parent/Guardian PRINTED Name *(Parent/Guardian not required if applicant is 18)*	Parent/Guardian SIGNATURE	Date
_____	_____	_____
(A) Applicant PRINTED Name	Applicant SIGNATURE	Date

PRESCRIPTION MEDICATIONS & ALLERGIES

APPLICANTS NAME: _____ _____ _____
Last First Middle I

Are you currently using any prescribed medications? ☐ Yes ☐ No

If yes, list all medications – dose and time taken:

Current Medications

Medicine	Dose	Time	How long have you been taking it?

Have you stopped taking prescription medications within the last 3 months? ☐ Yes or ☐ No

If yes, list medications – reasons for taking and reasons for discontinuing:

Medications Discontinued in past 3 months

Medicine	Reason for Medication	Why did you stop?

Allergies

Are you allergic to any medications, foods, or other agents such as bee stings, ragweed, etc.? ☐ ***Yes** ☐ **No**

If yes, explain: _____

** If you have a food allergy, please make sure your physician completes the Medical Statement to Request Special Meals and/or Accommodations Form.*

SIGNATURES:

I certify that I have reviewed the foregoing information, supplied by me, and that it is true and complete.

_____ _____ _____
(1) Parent/Guardian PRINTED Name | Parent/Guardian SIGNATURE | Date
(Parent/Guardian not required if applicant is 18)

_____ _____ _____
(A) Applicant PRINTED Name | Applicant SIGNATURE | Date

ALASKA MILITARY YOUTH ACADEMY PHYSICAL EXAMINATION FORM

PURPOSE: 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, or an Advanced Practice Nurse by the Board of Nurse Examiners. **Examination forms signed by any other health care practitioner will not be accepted. You may substitute this form but any substitution should include all the required information below. A school sports physical will be accepted.**

APPLICANTS NAME: _____ (Last) _____ (First) _____ (Middle) **DATE:** _____

Gender: ☐ Male ☐ Female **Age:** _____ **Date of Birth:** ____/____/____

Height: _____ **Weight:** _____ **P:** _____ **R:** _____ **B/P:** _____

Immunization Current: ☐ Yes or ☐ No **If not current, why?** _____

Vision: R 20/____ **L** 20/____ **Corrected?** ☐ Yes or ☐ No

Allergies: _____

_____

NORMAL	ABNORMAL		NORMAL	ABNORMAL	
		HEAD, FACE, NECK, SCALP			VASCULAR SYSTEM
		EARS – GENERAL			ABDOMEN & VISCERA (include hernia)
		DRUMS (PERFORATION)			ENDOCRINE SYSTEM
		NOSE			G-U SYSTEM
		SINUSES			UPPER EXTREMITIES
		MOUTH & THROAT			FEET
		EYES – GENERAL			LOWER EXTREMITIES
		OPTHALMASCOPIC			SPINE, OTHER MUSCULOSKELETAL
		PUPILS			IDENTIFYING BODY MARKS, SCARS, TATTOOS
		OCULAR MOTILITY			SKIN, LYMPHATIC
		LUNGS & CHEST			NEUROLOGICAL
		HEART			PSYCHIATRIC

☐ Cleared for Full Participation – No Restrictions

☐ Cleared after completing evaluation / rehabilitation for: _____

☐ Cleared for Participation with the following accommodations for: _____

- Diagnosis: _____
- Treatment Plan / Accommodations: _____

☐ Not cleared for: _____ Reason: _____

PHYSICIAN SIGNATURE:

_____ **Physician Printed Name & Signature**

_____ **Physician Phone #**

_____/_____/_____ **Date of Evaluation**

_____ **Physician Address**

_____ **Physician Fax #**

_____ **Physician E-mail**

Alaska Military Youth Academy
P O Box 5727 JBER, AK 99505-0727
Main Campus Medical: 1 (907) 428-7364 |Medical Fax: 1(907) 428-7386

Dear Health Care Provider:

Please complete this Physical Form for admission to Alaska Military Youth Academy (AMYA). AMYA is a volunteer program for youth 16-18 years of age who are at risk of not completing their high school education, located on JBER, Alaska. This program consists of a 22-week residential stay on JBER. The program training can be mentally and physically demanding. Physical training could include such physically strenuous activities as:

1. A daily run of two or more miles. 2. Daily vigorous physical exercises.

The program is structured with a quasi-military model, promoting personal time management, accountability, and promoting positive and negative consequences for behavior. Cadets will be expected to comply with rules and regulations.

Mental and emotional demands of the program include separation from family and loved ones, military style discipline, military ceremonial drill for prolonged periods of time, marching and physical training. Cadets will live in close communal barracks with up to 60 other cadets and must be able to cope with the inherent stress levels of barracks life.

We are staffed medically by an RN and Medical Provider who will see cadets for minor injuries and illnesses. **Medications will need to be maintained by the original prescriber throughout the student's stay at AMYA. Please provide or arrange for refills for the entire 5 months of their stay.**

This examination is for determining fitness to engage in strenuous activities and the highly structured, stressful environment as outlined above. The exam should be performed within the prior six (6) months of the first day of the class start date in most cases, exams may be accepted within 12 months if unable to update due to cost/location. A shorter time interval may be required in some cases.

Any questions you have concerning this examination or your patient's ability to participate can be answered by contacting our medical staff at 907-428-7364. All participants must have a physical, up to date immunizations, and, if required, additional mental health clearance.

Additional Medical Review may be conducted to determine acceptance for youth with:

- Bi-polar, Schizophrenia
- Extensive, recent drug history (within last 12 months)
- Congenital Heart Conditions
- Diabetes
- Immune Deficiency
- Kidney Failure
- Severe Respiratory disorder NOT controlled by an inhaler
- Cystic Fibrosis
- Marfan Syndrome
- Hemophilia/Blood Disorders

Youth with the following are not appropriate for AMYA

- Youth who require regular off campus appointments whether physical/mental/behavioral
- Intensive Outpatient Counseling/Therapy
- Active Audio Hallucinations
- AMYA cannot be a discharge plan/option from acute care

Included with the physical is a form regarding the Limited Medical Services at AMYA. In addition, families are to complete a Medical History and Prescription Medication & Allergies form that they have been asked to share with their Health Care Provider. There is also a form that is required IF a youth have food allergies.

Only for youth with food allergies Must be completed and signed by Medical Professional.

Child Nutrition Programs

Medical Statement to Request Special Meals and/or Accommodations

Please fax form to School or Child Care Provider

School or Child Care Provider Fax Number:

_____

The information on this form is CONFIDENTIAL and to be used for special dietary needs only

1. Parent, Guardian, Authorized Representative completes this section; complete a separate medical statement for each child.

Participant's Name	Name of Care Provider/Facility	Facility Telephone
Parent, Guardian, or Authorized Representative	Telephone of Parent/Guardian	Date

2. A Licensed Physician or Recognized Medical Authority check ONLY ONE box below. Please refer to regulatory definitions of disability and medical condition on reverse side of this form.

☐	**Participant is disabled or has a food related disability and requires a special meal or accommodation.** Provider or facility must comply with prescribed special meals and any adaptive equipment.
☐	**Participant is requesting a special meal accommodation due to allergies.** Substitutions and/or accommodations may be made, but are not required.

3. Disability or medical condition requiring a special meal accommodation:

4. If the participant has a disability, provide a brief description of participant's major life activity affected by the disability:

5. Diet prescription and/or accommodation: (Please describe in detail to ensure proper implementation)

6. Indicate Texture:

☐ **Regular** ☐ **Chopped** ☐ **Ground** ☐ **Pureed**

7. Please list specific foods to be omitted and suggested substitutions. Attach a sheet w/additional information if necessary.

Food(s)/food types to be omitted	Suggested substitution(s)

8. Adaptive Equipment:

9. A Licensed Physician signature is required for any participant with a disability. A Licensed Physician or Recognized Medical Authority signature is required for a student who must not eat certain foods due to medical issues or allergies.

Signature of Physician or Medical Authority	Printed Name & Title	Telephone	Date

"USDA and the State of Alaska are equal opportunity providers and employers"

Child Nutrition Programs

Medical Statement to Request Special Meals and/or Accommodations

A Licensed Physician (*for **disability**, allergy or food intolerance*) or Recognized Medical Authority (*for allergy or food intolerance*) must fill out a Medical Statement to Request Special Meals and/or Accommodations form and return it to the school, child or adult care facility/provider. Agencies have an obligation to provide alternate foods to those participants who have a disability, but are not required to provide food substitutions to those participants who are not disabled, but rather have food allergies. The two categories are listed below.

Participants with Disabilities
USDA Regulations require substitutions or modifications in child nutrition meals for children whose disabilities restrict their diet.

Participants with other special dietary needs
USDA regulations allow for substitutions for those participants in a USDA child nutrition program who are unable, because of medical or other special dietary needs, to consume foods that are being provided to the other participants.

Definitions:

"A Person with a Disability" is defined as any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment.

"Physical or mental impairment" means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

"Major life activities" are defined as "functions such as caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. As amended by the ADAAA, Major Life Activities now also includes "Major Bodily Functions" such as: "functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological , brain, respiratory, circulatory, cardiovascular, endocrine, and reproductive functions."

"Has a record of such an impairment" is defined as having a history of, or have been classified (or misclassified) as having a mental or physical impairment that substantially limits one or more major life activities.

"Recognized Medical Authority" means licensed physician, physician's assistant, or nurse practitioner.

The medical statement shall identify:

- The participant's disability or medical condition with an explanation of why the disability restricts the participant's diet;
- The major life activity affected by the disability;
- The specific diet or accommodation that has been prescribed by the medical authority. For example: "All foods must be in liquid or pureed form. Participant cannot consume any solid foods.",
- The type of texture of food that is required,
- The specific foods that must be omitted and suggested substitutions
- The specific equipment required to assist the participant with dining. Examples might include a sippy cup, a large handled spoon, wheel-chair accessible furniture, etc.

Citations: Rehabilitation Act of 1973, Section 504; 7 CFR Part 15 b; 7 CFR Sections 210.10(i)(1), 210.23(b); 215.14, 220.8(f), 225.16(g)(4), and 226.20(h); FNS Instructions 783-2, Rev. 2 and 784-3