Georgia Job ChalleNGe Academy

P.O. Box 3639
Fort Stewart, Georgia 31315
(912) 767-4619
www.georgiayouthchallenge.org

Please fill out the following documents and return them with your young adult on Reception Day.

Thank you.

PARENTAL CONSENT FOR MEDICAL CARE

(PLEASE PRINT IN BLACK/BLUE INK)

I/We the parent(s) or guardian(s) of Student: _____, enrolled in the Georgia National Guard Challenge Academy accept responsibility for the above-named student's medical costs. I/We will provide all the necessary information to bill for services rendered. I/We hereby consent in advance to all dental, medical, surgical and/or preventative medical treatment that is considered necessary in the best judgement of the attending physician in the event of illness or injury. I/We the parent(s) or guardian(s) of the above- named student give permission for any medical facility to release medical information to the Job Challenge Academy (JCA). I/We understand that my/our dependent has the right to apply for "Right from The Start Medicaid" (RSM) while participating in the Georgia National Guard Job Challenge Academy. I/We Understand these benefits will have to be released while my dependent is attending the program. I/We understand that here is the possibility that my dependent may not be accepted by the "Right from The Start Medicaid" in which case I/We are responsible for their medical costs over and beyond what Job Challenge Academy routinely provides.

_____ _____

Parent/Guardian (PRINT NAME) Relationship to Student

_____ _____

Parent/Guardian (Signature) Date

_____ _____

Parent Guardian DOB Parent/Guardian SSN

Medical Information: This section must be completed. – Please include a clear photocopy of the front and back of Medicaid: Peachcare. Wellcare, AmeriGroup, Peach State Card(s).

Do you have Medicaid? Yes ____ No ____ Student's Medicaid #: _____

Student's SSN: _____ Student's DOB: _____

Is Student Allergic to any medications, foods, or other things? Please list below:

1. Medications: _____
2. Food(s)/Others: _____

Parent/Guardian (Print Name) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

Medical Insurance information coverage: Please include a clear photocopy of front and back of card(s). Please provide original card to be kept on file until student(s) is released from program:

Name of Primary Insurance Company: _____

Cardholder's Name: _____ Cardholder's DOB: _____

Policy Number: _____ Group Number: _____ Plan number: _____

Name of Secondary Insurance Company: _____

Cardholder's Name: _____ Cardholder's DOB: _____

Policy Number: _____ Group Number: _____ Plan number: _____

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COVID-19 VACCINE Facts and Consent Form

- The Centers for Disease Control and Prevention (CDC) recommends everyone 12 years of age and older to receive COVID-19 vaccine to help protect against COVID-19.
- People at high risk of serious coronavirus complications include young children, pregnant women, people with chronic health conditions like asthma, heart disease, diabetes and lung disease and people 65 years of age and older.
- It takes about two weeks after vaccination for the immune system to fully respond to the vaccine and provide the body protection.
- Children 12 years old who are getting vaccinated for the first time will need two doses of the Pfizer and Moderna vaccine and one dose of the Johnson & Johnson vaccine.
- Coronavirus symptoms can include coughing, sore throat, runny or stuffy nose, muscle aches or body aches, headaches, fatigue, and in most cases high fever. Some people may have vomiting or diarrhea, and more server complications and possible no symptoms.
- Getting vaccinated not only protects you, but it also protects people around you – like babies, older people, and people with chronic health conditions – who may be at risk from getting seriously ill from COVID-19.
- According to The Centers for Disease Control and Prevention (CDC), the COVID-19 shot given during pregnancy has been shown to protect both the mother and her baby and has not caused any fertility issues.
- The vaccine might cause some mild side effects such as low-grade fever, aches or redness/swelling where the shot was given, headache, muscle pain and chills but it does not cause COVID-19.

I give consent for Associate _____ to receive the COVID-19 vaccine.

I **do** not give consent for Associate _____ to receive the COVID-19 vaccine.

By signing below, I give permission for my child to receive the COVID-19 vaccination at the GA Job Challenge Academy which will be administered by LIBERTY COUNTY HEALTH DEPARTMENT. I understand that my child will receive the COVID-19 vaccine based on the medical information provided by myself, the parent/guardian. I have had a chance to ask questions, which were answered to my satisfaction. I understand the benefits and risks of the COVID-19 vaccine that will be given to the child that I am authorized to represent.

Signature of Parent/Legal Guardian: _____

Date: _____

Print name of Parent/Legal Guardian: _____

Date: _____

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Covid-19 Testing: Informed Consent

Please read carefully and sign the following Informed Consent:

a. I authorize my child to have a COVID-19 test conducted through a nasopharyngeal swab, as ordered by an authorized medical provider.
b. I authorize my child's test result to be disclosed to the County, State, or to any other governmental entity as may be required by law.
c. I acknowledge that a positive test result will result in my child returning home within 24 hrs. of confirmation. My child will be quarantined until they are picked up by parent/guardian.
d. I understand that the GA YCA/JCA is not acting as my medical provider, this testing does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action with regards to my child's test results. I agree that I will seek medical advice, care, and treatment from my child's medical provider if I have questions or concerns, or if my child's condition worsens.
e. I understand that, as with any medical test, there is a potential for a false positive or false negative COVID-19 test result.

I the undersigned, have been informed about the test purpose, procedure, possible benefits, and risks, and I have received a copy of this informed consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask additional questions at any time. I voluntarily agree to this testing for COVID-19.

Date: _____

First Name: _____ Last Name: _____

Signature of Parent/Guardian: _____

Job ChalleNGe Academy Use of Drugs Policy

Testing:

Job ChalleNGe Academy, JCA, students are agreeing to random drug testing to ensure their commitment to be drug free. Initially you will be tested sometime during the first 30-day period and any time after your enrollment. The program reserves the right to randomly test participants during their enrollment, and to test any participants where there is reasonable suspicion the student is under the influence of drugs and/or abusing alcohol.

Positive Testing Results:

Students will be asked, once again, to make commitment to being drug free and valuing the program's drug free policy. Participants testing positive will be referred to the Director for immediate dismissal. Completion of JCA is mandated by you continuing to be drug free.

Medically Prescribed Medications:

While the use of medically prescribed medications is not by itself a violation of this policy, failure to turn over all prescribed medication or over the counter medication to JCA staff immediately is a violation of this policy. Taking medications that have the potential to interfere with the safety and wellbeing of yourself or have known side effects that may cause harm or cause you to act in a dangerous manner and result in immediate school dismissal.

It is the responsibility of the student, while taking medically prescribed medications, to act responsibly in their behavior and at no time authorized to share, give or allow someone other than the prescribed individual to consume their medication. This includes selling or giving at no cost.

Possession of Tobacco Product

Job ChalleNGe Academy supports the school's efforts to maintain a "Tobacco Free Zone". Smoking, chewing, and vaporizing (e-cigarettes) are NOT allowed on the JCA school campus. When at a JCA event/activity, community service site or a JCA building. Those caught using tobacco will be disciplined in accordance with school policies and by local laws as it applies.

Summary of Acceptance and Commitment:

- By accepting enrollment into the Job ChalleNGe Academy, you are agreeing to:
- Random drug testing
- Testing positive is cause for immediate school dismissal and punishable by law.
- Use of tobacco product is care for discipline with school policies and local laws as it applies.

_____ _____

Printed name of student **Date**

_____ _____

Signature of student **Program Staff Signature**

_____ _____

Parent/Guardian Signature **Date**

COVID-19

Pre-Screen Check List

Name: _____ **Date:** _____

1. Are you a student ☐ Visitor ☐ Parent ☐ Mentor ☐ Other ☐
2. In the past 14 days, have you traveled out of the country with travel advisories or affected areas in the US, or been on an airplane or cruise? Yes ☐ No ☐
3. In the past 14 days have you had close contact with anyone suspected or identified with COVID-19 (Coronavirus)? Example: Share same residence, workspace, or within 6 feet of person. Yes ☐ No ☐
4. Do you currently have any of the following symptoms? Yes ☐ No ☐

If yes, please check all that apply

☐ Fever (100.4 or subjective fever) ☐ New or Worsening Cough

☐ New or Worsening Shortness of Breath

If you have answered that you are currently experiencing symptoms of respiratory illness and fever, please contact your primary care provider or consider the Emergency Department for evaluation.

Job Challenge Academy will be adhering to the CDC and applicable guidelines to keep our Staff and Students safe.

All incoming associates must have a pre-screen completed prior to attending JCA. All Associates will be screened again prior to being allowed onto the JCA campus. Any Associate who doesn't pass the acceptance screen must return home with Parent/Legal Guardian.

All parties arriving with the Associate must have completed a pre-screen form. This is to protect yourself, your child, and others.

Georgia Job Challenge Academy

Prescription Medication(s) Agreement

I/We, the parent(s) or guardian(s) of Associate _____ enrolled in the Georgia National Guard Job Challenge Academy acknowledges the fact that my child is taking the prescribed medication(s) listed below as directed by his/her physician. **I accept responsibility for providing adequate supply of medications for the duration of the program.**

The Academy staff must hold all associated to the same standards of conduct, including those receiving mediation therapies to manage symptoms of a psychiatric condition. Should your child begin to manifest symptoms of a mental condition, or otherwise lose his/her ability to cope with JCA life, the academy will notify you immediately. Depending on the symptom's severity, the associate may be dismissed at that time, or the academy may refer the associate to his/her primary physician for an assessment/reassessment. Parents are responsible for making the appointment and transporting the associate to and from the doctor's office. Such medical passes authorize only the time necessary for treatment. Associates must return to the campus immediately after. Too many days off campus violates the National Guard and Technical College attendance policy and may disqualify the associate for graduation. Return to campus is no automatic, however, the academy may authorize the associates return to the program on condition that the attending physician recommends it, the associate wishes to remain in the program, and he/she can maintain the academy's standards of conduct and performance. **Parents will remain responsible for their associate's medication refills throughout the program and must be mindful and not allow the associate to exhaust his/her medication supply, which could result in the associates dismissal.**

For all associates, the following are symptoms that may prompt a referral to a primary physician for evaluation or re-evaluation.

Apathy; unconcerned about anything; lack of sustained attention; complaints of pains; headaches, stomachaches; low back pain, or fatigue; rides sick-call; poor listener; difficulty concentrating; remembering details and making decisions; failure to follow through on tasks; excessive or inappropriate guilt about past events; poor organization; irresponsible behavior- for example, forgetting obligation; avoiding class; avoiding tasks requiring sustained mental effort; loss of interest in food or rapid; losing things; memory loss; easily distracted; preoccupation with death or dying, forgetful in daily activities; sadness, anxiety or feeling of hopelessness; fidgeting/squirming,; staying awake at night and attempting to sleep during the day; leaving seat; unmotivated in class; difficult with quiet activities; feels irritable ad throws violent temper tantrums; "on the go", seems extremely happy and have high energy level; excessive talking; often spends time alone and may easily feel rejected or criticized; blurting out answer, moves very slowly; cant wait turn; fatigue and decreased energy; lack of sustained attention; insomnia; early-morning wakefulness; excessive sleeping; thought of suicide; attempt of suicide; careless mistakes/lack of attention to details.

Parent/Guardian (print name) _____ **Parent/Guardian Signature** _____

Relationship to Associate: _____ **Date:** _____

Home Phone #: _____ **Cell Phone #:** _____

Work Phone #: _____ **Alternate #:** _____

Parent/Guardian E-mail address:

Taking Medications at the present time:	Yes ☐	No ☐	List Medications or Food Allergies:
Psychotropic Drugs in the last 5 years:	Yes ☐	No ☐	

List any an all medications your child is currently taking and reason for taking Prescription and over the counter below: (if NONE, state NONE)

Name of Medications & Dosage/Route	Reason for Use	Time (AM; PM; etc.)	Date of last dosage

Georgia Job Challenge Academy
TRUTHFUL DISCLOSURE

Associate Name (Print): _____ Trade: _____

TRUTHFUL DISCLOSURE:

I do hereby affirm that the information I provide on the application and forms required by the Fort Stewart Job Challenge Academy is accurate and truthful to the best of my knowledge. I understand that if I withhold pertinent information or provide false information regarding my child that not only can I jeopardize my child's safety and well-being but that my child may be discharged from the program upon discovery of such information.

Have you ever been treated for (circle all that apply):

Mental Health: Attention Deficit/Hyperactive Disorder (ADD or ADHD) Bipolar Disorder Depression Bulimia Conduct Disorder Panic Disorder Anxiety Disorder Panic Attacks Schizophrenia Anti-Social Personality Disorder Autism Spectrum Disorder (i.e., Asperger's or Autism)

Oppositional Defiant (ODD) Compulsive Disorder PTSD (Post Traumatic Stress Disorder) Anorexia Nervosa

Has Associate seen: Psychologist, Counselor, Professional for any reason Yes ☐ No ☐

Any attempt to hurt his/herself? Yes ☐ No ☐ If yes, date/year _____ Age: _____

Alcohol of Choice: Beer Wine Liquor Other _____

How often do you drink alcohol? _____

Rehab for Drug or Alcohol Abuse? Yes ☐ No ☐ If yes, date/year _____

Have you ever used: Marijuana Crack Cocaine Heroin Cigarettes Other (list)

_____

History of bedwetting (Nocturnal enuresis)? Yes ☐ No ☐

Do you wear (circle one) glasses or contact lenses? Yes ☐ No ☐ Date of last exam:

_____

Parent/Guardian (Print Name): _____

Signature:_____ **Date:** _____

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FAX (912) 767-3134

Flu Vaccine Facts and Consent Form

- The Centers for Disease Control and Prevention (CDC) recommends everyone 6 months of age and older to receive a yearly flu vaccine.
- People at high risk of serious flu complications include young children, pregnant women, people with chronic health conditions like asthma, heart disease, diabetes and lung disease and people 65 years of age and older.
- It takes about two weeks after vaccination for the immune system to fully respond to the vaccine and provide the body protection.
- Children 6 months through 8 years old who are getting vaccinated for the first time will need two doses of the vaccine.
- Flu symptoms can include coughing, sore throat, runny or stuffy nose, muscle aches or body aches, headaches, fatigue, and in some cases, high fever. Some people may have vomiting or diarrhea, though this is more common in children than adults.
- Getting vaccinated not only protects you, but it also protects people around you – like babies, older people, and people with chronic health conditions – who may be at risk from getting seriously ill from the flu.
- According to The Centers for Disease Control and Prevention (CDC), the COVID-19 shot given during pregnancy has been shown to protect both the mother and her baby for several months after birth from the flu.
- The vaccine might cause some mild side effects such as low-grade fever, aches or redness/swelling where the shot was given, headache, muscle pain and chills but it does not cause the flu.

I give consent for Associate _____ to receive the Influenza Vaccine.

I **do** not give consent for Associate _____ to receive the Influenza Vaccine.

By signing below, I give permission for my child to receive the Influenza vaccination at the GA Job Challenge Academy which will be administered by LIBERTY COUNTY HEALTH DEPARTMENT. I understand that my child will receive the Flu vaccine based on the medical information provided by myself, the parent/guardian. I have had a chance to ask questions, which were answered to my satisfaction. I understand the benefits and risks of the Influenza vaccine that will be given to the child that I am authorized to represent.

Signature of Parent/Legal Guardian: _____

Date: _____

Print name of Parent/Legal Guardian: _____

Date: _____

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Media/Photograph/Video Release Form

I agree to have my young adult's name released to the news media for publication, or to be contacted by any news media for interview concerning participation in the Georgia Job ChalleNGe Academy. I further release all rights to photographic images taken of my child. This release is to discharge all claims and demands arising out of or in connection with the use of photographs/videos. I grant Georgia Job ChalleNGe Academy the right to identify my child by name.

_____ I Consent

_____ I Do Not Consent

_____

Print Associate Name

_____ _____

Parent/Guardian Signature

Date of Signature

Applicant Signature if 18 or older

JOB CHALLENGE ACADEMY
STUDENT DATA SHEET

Students Name: _____

Current Age: _____ DOB: _____ Graduation Age: _____

Parent/Guardian Name: _____

Relationship of Person Above (Mother, Father, Stepfather, etc.): _____

Address of Parent/Guardian

City: _____State: _____ Zip: _____County: _____

Phone #: _____ Cell #: _____

Work #: _____

Current Medications: _____

Diagnosis: _____

Previous Medications: _____

Diagnosis:

NAMES	HOME PHONE	CELL PHONE	WORK PHONE
Mother			
Father			
Stepmother			
Stepfather			
Mentor			
Brothers and Sisters, the live with you (same household)			

List your 1st Choice to contact: _____ List 2nd Choice: _____

Court Involvement: Yes ☐ No ☐

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PARENT COMMITMENT CONTACT

As a Parent/Guardian of the Associate/Student herein named:

_____

I will do everything within my power to achieve the following:

Encourage my associate to complete the program. Remind them that quitting is not an option and to stay focused on the mission at hand. Provide the necessary support and encouragement to maintain their motivation to complete the program.

Assist my associate in adapting to the JCA structure and reinforce the JCA staff judgements as appropriate. I will provide a strong family support system and promise to do my best during the entire tenure of JCA Residential and Post-Residential Phase.

I will write to my associate at least once bi-weekly.

I will communicate by phone at least once a month.

I will notify the JCA staff first in case of emergencies.

I will arrange with my associate all transportation needs for weekend passes and/or authorized home visits. I will ensure the departure and return timeline is followed.

I will work closely with the assigned mentor for my associate during the 12-18 months Post-Residential Phase. I will encourage enrollment in further education programs and/or attaining full-time employment.

_____ _____

Parent Signature Date

_____

Printed Associate Name

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ASSOCIATES COMMITMENT CONTRACT

As an Associate/Student in the Job ChalleNGe Academy (JCA), I will do everything within my power to achieve the following objectives:

1. Function as a contributing member of the JCA community and a team player. This will help me develop a positive self-image, instill self-discipline, maintain my motivation, and support my commitment to the academy.
2. Succeed in my chosen career and control my family affairs. I will develop and maintain a strong desire for self-improvement in education, values, and life skills.
3. Furthermore, I will outwardly demonstrate this desire by giving full cooperation to my instructors, JCA staff, and the mentor during both the Residential and Post-Residential Phase. I agree to obey all rules and regulations set forth by JCA.
4. Complete the program. I understand that the JCA is specifically designed to help me reach my objectives. I will remain open and candid with my instructors, counselors, and JCA staff members concerning issues that impact my commitment to JCA.

_____ _____

Associate Printed Name Date

_____

Associate Signature

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I understand that the overall goal of the Job ChalleNGe Academy is occupational Job training. I must enroll, attend, and successfully complete this training.

I understand that upon completion of training, I will receive college credits, industry-recognized certification, or both.

These credentials can result in job placement or serve as steppingstones to a long-term career.

_____ _____

Associate Name Date

_____

Associate Signature