



# Georgia Youth ChalleNGe Program

## Candidate Application Documents



Dear Applicant:

Thank you for your interest in the Georgia Youth ChalleNGe Program. You have completed the first step in the application and selection process for the program by submitting the online application. Submission of the Online Application alone does not guarantee your acceptance into program.

GaYCP class selection is made by the campus staff and is based on various factors. The application & selection process considers your application for the next available class start date regardless of the campus location. You should not expect to be selected for a specific campus location.

**These steps are required for your application to be considered:**

### **Submission of required documentation:**

You must submit the required documents listed below before your file can be reviewed for your eligibility and suitability into the program. Please read every page of the Candidate Application Documents carefully. Make sure that all pages are filled out completely, legibly and are signed by Parents/Guardians and Student where it is required.

If necessary, these individual GaYCP forms can be found on the Georgia Youth ChalleNGe Program website under Admissions/Required documents link. [www.georgiayouthchallenge.org](http://www.georgiayouthchallenge.org)

It is recommended that you keep a copy of your completed application documents for your personal records.

- ✓ **Legal History Form (with copies of official court documents)**
- ✓ **Mental Health Information Form**
- ✓ **Medical History Form**
- ✓ **A copy of your Birth Certificate**
- ✓ **Immunization Record**
- ✓ **Academic Transcripts**
- ✓ **School Behavioral and Attendance Records**
- ✓ **Individualized Education Plan Documentation**
- ✓ **Completed Mentor Application (completed and signed by the Mentor)**
- ✓ **High School Withdrawal Form**
- ✓ **A copy of your Social Security Card**
- ✓ **Your Government Issued Identification Card**
- ✓ **Academic Records Request Form (must be taken to your school)**

**You should complete and e-mail the documents listed above to: [documents@gaycp.org](mailto:documents@gaycp.org)**

### **Complete a Virtual Mandatory Orientation event:**

Once your completed file has been received and reviewed by the campus staff, and if you are selected for admission, you will be invited to complete a mandatory virtual orientation event. A link to the virtual event will be sent to you by the campus staff. You will be required to provide the certificate of completion to the campus upon arrival for your campus intake Day.



# Georgia Youth ChalleNGe Program Candidate Application Documents



Print Please

The submitted documents are for the following applicant:

### Applicant Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_

Email \_\_\_\_\_

Date of Birth (mm/dd/yyyy) \_\_\_\_\_ Current Age \_\_\_\_\_

(You must be between 16 and 18 years of age as of the first day of the YCA class date for which you are applying. If not yet eligible due to your age, your file will be held in a pending status until you become eligible for enrollment)

### Parent/Guardian

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Email \_\_\_\_\_

**NOTE: *It is requested that you DO NOT submit individual images of documents with your phone due to the image quality and clarity issues. PDF documents are acceptable.***

**It is highly recommended that you keep a copy of your completed application documents for your personal records.**

As your application documents are collected, the campus selection committee will review them and will inform you of their decision on your selection. They may also contact you for clarification of information that you may have provided.



# Georgia Youth ChalleNGe Program

## LEGAL HISTORY FORM

**PLEASE READ**

**This Form Must be Completed**

Applicants cannot currently be on parole or probation for other than juvenile offenses, nor not awaiting sentencing, and not under indictment, charged, or convicted of a crime that is considered a felony that could, will or has been tried in an adult court.

**ANY FALSE OR MISLEADING INFORMATION COULD RESULT IN DENIAL OF YOUR APPLICATION OR TERMINATION FROM PROGRAM**

**Print Applicant's Name:** \_\_\_\_\_

Have you ever appeared in a CRIMINAL or CIVIL COURT, including Juvenile Court, for any offense:  
YES\_\_\_NO\_\_\_Are you awaiting trial? YES\_\_\_\_NO\_\_\_\_

Have you ever been Arrested or Convicted of a Misdemeanor or Felony? YES\_\_\_NO\_\_\_  
If yes, explain:

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Are you currently on probation, house arrest, or in-home detention? YES\_\_\_NO\_\_\_  
If yes, explain

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4- Do you have a pending court date? YES\_\_\_NO\_\_\_\_  
If yes, please explain:

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5- Are you currently on probation, house arrest, or in-home detention? YES\_\_\_NO\_\_\_\_  
If yes, please explain:

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Applicant Name \_\_\_\_\_

Please provide the following contact information below:

Name of your Probation Officer: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_

Use this space for further explanation of your previous answers:

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To the best of my knowledge, all statements made by me on this application are truthful. I am in good health, drug free, and do not have an alcohol problem. I am not serving a sentence under auspices of any facet of the legal system and I am not on probation. I understand that this is a “DRUG & TOBACCO-FREE” Academy.

**PLEASE SIGN**

Applicant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**YOU MUST ATTACH ALL DOCUMENTS RELATING TO THE INCIDENT’S LISTED ABOVE  
(disposition, or proof of outcome showing the status of charge (misdemeanor/felony))**

You can submit this form with additional documents to the following:

Email: [documents@gaycp.org](mailto:documents@gaycp.org)



This form is to be completed by the Guardian

## Georgia Youth Challenge Program MEDICAL HISTORY FORM

Applicant Name		Social Security Number		Age
Present Statement of Health	Allergies		Current Medications & Dosages	
Height	Weight		Right Handed <input type="radio"/> Left Handed <input type="radio"/>	
<b>DO YOU HAVE OR EVER HAD:</b>	<b>Yes</b>	<b>No</b>	<b>If you marked yes, and the condition has been present in the last five (5) years, please explain.</b>	
Household contact with anyone who has tuberculosis				
Tuberculosis or positive TB test				
Blood in saliva or when coughing				
Excessive bleeding after injury or dental work				
Suicide attempt or plans				
Sleep-walking				
Wear corrective lenses				
Eye surgery to correct vision				
Lack vision in either eye				
Wear hearing aid				
Stutter or stammer				
Wear a brace or back support				
Scarlet fever				
Rheumatic fever				
Swollen or painful joints				
Frequent or severe headaches				
Dizziness or fainting spells				
Hearing loss				
STD/syphilis/gonorrhea, etc.				
Recent gain/loss of weight				
Loss of finger/toe				
Bed-wetting since age 12				
Kidney stone/blood in urine				
Diabetes or hypoglycemia				

DO YOU HAVE OR EVER HAD:	Yes	No	If you marked yes, and the condition has been present in the last five (5) years, please explain and include the date.
Recurrent ear infections			
Shortness of breath			
Chronic cough			
Palpitation or pounding heart			
Heart trouble			
High or low blood pressure			
Frequent leg cramps			
Frequent indigestion			
Stomach, liver, intestinal trouble			
Gall bladder trouble or gallstones			
Jaundice or hepatitis			
Broken bones			
Skin diseases			
Tumor, growth, cyst, or cancer			
Hernia			
Hemorrhoids or rectal disease			
Frequent or painful urination			
Eating disorder			
Thyroid trouble or goiter			
Arthritis, rheumatism, or bursitis			
Bone, joint, or other deformity			
Painful or "trick" shoulder or elbow			
Recurrent back pain or any back injury			
Trick or locked knee			
Foot trouble			
Nerve injury			
Paralysis			
Epilepsy or seizures			
Car, train, or air sickness			
Chronic depression			
Loss of memory or amnesia			
Periods of unconsciousness			
X-ray or any radiation therapy			
Chemotherapy			

DO YOU HAVE OR EVER HAD:	Yes	No	If you marked yes, and the condition has been present in the last five (5) years, please explain and include the date.	
Sinusitis or hay fever				
Asthma				
Tire easily				
Pain or pressure in chest				
Sensitivity to chemicals, dust, sunlight, etc.				
Inability to perform certain motions				
Inability to assume certain positions				
Have you ever been treated for a mental condition?				
Have you had, or have you been advised to have, any operations?				
Have you been a patient in any type of hospital?				
Have you ever had any illness or injury other than those already noted?				
Exposure to asbestos or toxic chemicals?				
Have you ever been diagnosed with a learning disability?				
Used illegal substance / Use tobacco?				
Female Only			Date of last Menstrual Period	Date last PAP smear
Treated for a female disorder				
Change in menstrual pattern				

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

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**Parent or Guardian Signature & Date**



# Georgia Youth Challenge Program

## MEDICAL INSURANCE INFORMATION SHEET

*This information sheet must be completed for the applicant to be enrolled in Georgia Youth Challenge Program.*

CANDIDATE'S BIRTH NAME: \_\_\_\_\_ SSN: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

(STREET) (CITY) (STATE) (ZIP)

PARENT/GUARDIAN NAME: \_\_\_\_\_ SSN: \_\_\_\_\_

**DO NOT CURRENTLY HAVE ANY TYPE OF MEDICAL INSURANCE? \_\_\_\_\_ YES NO IF YOUR ANSWER IS YES, PLEASE COMPLETE THE FOLLOWING:**

**ARE YOU CURRENTLY ON MEDICAID? : YES NO MEDICAID ACCT# \_\_\_\_\_**

COUNTY IN WHICH APPLICANT IS CURRENTLY ENROLLED: \_\_\_\_\_

**MILITARY DEPENDENT? : YES NO \_\_\_\_\_**

IF YES, SPONSOR'S NAME: \_\_\_\_\_ SSN: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

(STREET) (CITY) (STATE) (ZIP) TRICARE

ACCOUNT NUMBER: \_\_\_\_\_

SPONSOR'S MILITARY UNIT: \_\_\_\_\_ UNIT PHONE: \_\_\_\_\_

**PRIMARY INSURANCE:**

NAME: \_\_\_\_\_ POLICY NUMBER: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_ POLICY HOLDER: \_\_\_\_\_

INSURANCE COMPANY ADDRESS:

\_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

INSURANCE COMPANY PHONE NUMBER: (\_\_\_\_\_) \_\_\_\_\_

**SECONDARY INSURANCE:**

NAME: \_\_\_\_\_ POLICY NUMBER: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_ POLICY HOLDER: \_\_\_\_\_

INSURANCE COMPANY ADDRESS:

\_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP) INSURANCE

COMPANY PHONE NUMBER: (\_\_\_\_\_) \_\_\_\_\_





## GaYCP Mental Health Information Form To be completed by a medical/mental health provider

Patient Name: \_\_\_\_\_ Parent Name: \_\_\_\_\_

We are requesting you to evaluate the mental readiness of this person to attend the Georgia Youth Challenge Academy Program (GYCP). We want to ensure that the student’s attendance will “do no harm.” To help in this evaluation, we are providing some basic information.

GYCA is a 5-month, intense residential quasi-military program focused on discipline and academic excellence. While in a structured, disciplined environment, students will be expected to participate in the program’s eight core components in: Leadership/Followership, Service to Community, Job Skills, Academic Excellence, Responsible Citizenship, Life-Coping Skills, Health & Hygiene, and Physical Fitness. While here, students live in a military dorm with upwards of 50 other individuals; follow military customs such as marching, participating in physical training 5-days per week starting at 6:00 AM, going to bed at 9:00 PM, and having their entire day regimented.

GYCP has career counselors, but it does not provide mental health counseling; therefore, it is not recommended for individuals requiring intense mental health treatment. Parents and or Guardians will be responsible for arranging any mental health follow up appointments during (2) scheduled passes. Additional days away from training could disqualify the student for graduation, having not completed the mandatory number of days of training. Contact us, if you have questions.

**Yes or No** *(Circle One) This student is not currently or has never been seen by a Mental Health Provider for any reason. If answered Yes, then have a medical/mental health provider complete the remainder of this form.*

**Please provide the following information of the student’s current status**

### CURRENT MENTAL HEALTH INFORMATION

Attending Provider: \_\_\_\_\_

Provider’s Address: \_\_\_\_\_

Provider’s Phone: \_\_\_\_\_

Current diagnosis and date: \_\_\_\_\_

Dates of treatment (starting date – ending date & frequency of sessions):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CURRENT MENTAL HEATH INFORMATION**

Current Medication(s) prescribed: Include dosage and frequency

1) \_\_\_\_\_

Start Date \_\_\_\_\_ Purpose \_\_\_\_\_

2) \_\_\_\_\_

Start Date \_\_\_\_\_ Purpose \_\_\_\_\_

3) \_\_\_\_\_

Start Date \_\_\_\_\_ Purpose \_\_\_\_\_

4) \_\_\_\_\_

Start Date \_\_\_\_\_ Purpose \_\_\_\_\_

Date of Next Appointment: \_\_\_\_\_

In your opinion, does the student pose a threat to himself or others? \_\_\_\_\_

In your opinion, will the student require on-going psychotherapy in addition to medication?

In your opinion, will the student be able to cope with residing in an open bay dormitory along with approximately fifty (50) students for five months with staff supervision? If no, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In your opinion, will the student be able to largely self-manage his/her behavior and willingly take medication as prescribed with minimal supervision? \_\_\_\_\_ if no, please explain

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mental Health Provider/Physician Signature \_\_\_\_\_

Date: \_\_\_\_\_



## **GYCP MENTOR PROSPECT**

The Post-Residential Phase of the Georgia Youth Challenge Program is crucial to the long-term success of graduates. The goal of the Post-Residential Phase is to ensure graduates achieve their identified goals and remain free from criminal activity and substance-abuse problems. Mentors who are committed to helping the young person they volunteer to assist, are indispensable in the Post-Residential Phase, and ultimately, to the long-term success of the graduate.

Good mentors may be found in many places: youth workers, teachers, religious leaders, coaches, business professionals, community workers, good neighbors. It is best if the candidate already has a relationship or knows the potential mentor.

### **QUALIFICATIONS OF A MENTOR**

- Be at least 21 years old and the same gender as the candidate.
- Be able to successfully pass a criminal background check.
- Not live in the same house, be a close relative, the girlfriend/boyfriend's parent, or the employer, or the candidate or his/her parents or guardian.
- Capable of being a role model who demonstrates by example the types of life-skills, work-ethics and attitudes needed to be a productive member of society.

### **ACADEMY'S EXPECTATION OF MENTORS**

- Attend a four (4) hour mentor training session that will be provided (discussed below).
- Write cadet and provide encouragement during the five (5) month residential phase.
- Contact the graduated cadet at least once a week (face-to-face at least twice a month) during the twelve (12) month Post-Residential Phase following graduation.
- Provide guidance for social development and achievement of the graduate's goals after graduation

### **MENTOR TRAINING**

All individuals volunteering to be a mentor; **MUST ATTEND MENTOR TRAINING**. Individuals will receive training in program requirements, supervision and guidance of at-risk youth, available support resources, and the actual role of a mentor. Each mentor will receive more information regarding training after the youth has been accepted. Mentors are required to attend one training session. For additional information, contact at Fort Stewart, Ms. Fisher at (912) 876-1743/1745; or at Fort Gordon, Ms. Howard at (706) 823-9274.

NAME OF THE STUDENT I WISH TO MENTOR: \_\_\_\_\_

## MENTOR APPLICATION FORM

DATE OF BIRTH: \_\_\_\_\_ (MUST PROVIDE IN ORDER TO PROCESS)

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MIDDLE NAME: \_\_\_\_\_

\*ETHNICITY (Circle One): American Indian/Alaskan Asian or Pacific Islander  
 Black not of Hispanic Origin Hispanic Multiracial Other White not of Hispanic Origin  
 GENDER (Circle One): Male Female MARITAL STATUS (Circle One): Married Single Widowed  
 SPOUSE'S NAME: \_\_\_\_\_ NUMBER OF CHILDREN: \_\_\_\_\_

### EMPLOYMENT INFORMATION

OCCUPATION: \_\_\_\_\_  
 EMPLOYMENT STATUS (Circle One): Full-Time Part-Time Volunteer Retired Unemployed  
 ORGANIZATION: \_\_\_\_\_ HOW LONG EMPLOYED? \_\_\_\_\_  
 PHONE NUMBER: (\_\_\_\_) \_\_\_\_\_ FAX NUMBER: (\_\_\_\_) \_\_\_\_\_

EMPLOYMENT HISTORY FOR LAST FIVE (5) YEARS:

POSITION	EMPLOYER	HOW LONG EMPLOYED	REASON FOR LEAVING

### HOME ADDRESS INFORMATION

STREET ADDRESS: \_\_\_\_\_ COUNTY: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 HOME PHONE: (\_\_\_\_) \_\_\_\_\_ CELL: (\_\_\_\_) \_\_\_\_\_  
 PAGER: (\_\_\_\_) \_\_\_\_\_ E-MAIL: \_\_\_\_\_

### DRIVING & LEGAL INFORMATION

DO YOU HAVE YOUR OWN TRANSPORTATION? Yes No  
 DO YOU HAVE CAR INSURANCE? Yes No  
 IF NO, DO YOU HAVE ACCESS TO TRANSPORTATION? Yes No WOULD  
 YOU BE ABLE TO ATTEND MENTOR TRAINING? Yes No HAVE YOU  
 EVER USED ILLEGAL DRUGS? Yes No  
 IF YES, WHEN AND WHAT TYPE OF DRUGS? \_\_\_\_\_

THIS INFORMATION WILL BE USED FOR STATISTICAL DATA ONLY.

NAME OF THE STUDENT I WISH TO MENTOR: \_\_\_\_\_

YOUTH EXPERIENCE

HOW LONG HAVE YOU KNOWN THE CANDIDATE? \_\_\_\_\_

PLEASE EXPLAIN HOW YOU CAME TO KNOW THE CANDIDATE YOU WISH TO MENTOR: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

REFERENCES---PROVIDE FOUR (4), NON-RELATED (EMPLOYER, CLERGY, FRIEND)

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE: (\_\_\_\_\_) \_\_\_\_\_ WORK PHONE: (\_\_\_\_\_) \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE: (\_\_\_\_\_) \_\_\_\_\_ WORK PHONE: (\_\_\_\_\_) \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE: (\_\_\_\_\_) \_\_\_\_\_ WORK PHONE: (\_\_\_\_\_) \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE: (\_\_\_\_\_) \_\_\_\_\_ WORK PHONE: (\_\_\_\_\_) \_\_\_\_\_

I do not presently have any cases pending against me in the legal system and I am in good health. I am not nor will I be, drug or alcohol-dependent during my mentorship. The information provided is true and accurate to the best of my knowledge. I will report any and all changes in my application information to Georgia Youth Challenge Program.

Mentor's Signature \_\_\_\_\_ Date \_\_\_\_\_



NAME OF THE STUDENT I WISH TO MENTOR: \_\_\_\_\_

## Mentor Liability Release

I understand and agree that I will be the one actually spending time with my matched GYCP graduate, and that I must exercise care in supervising my mentee while we are together. I also understand and agree that I am not a Georgia Youth ChalleNGe Program agent, and that I am responsible for choosing and conducting all activities with my mentee, and that ChalleNGe does not retain any power to control how these activities are conducted except to require these activities to be conducted in the State of Georgia \_\_\_\_\_.

I therefore agree that Georgia Youth ChalleNGe will not be liable for, and I agree to hold Georgia Youth ChalleNGe harmless from any and all liability, causes of action and losses imposed on it in any way relating to or arising out of this mentoring agreement, including, but not limited to, liability for personal injuries, whether the liability, cause of action, or loss is caused by my negligence, or Georgia Youth ChalleNGe negligence, or otherwise.

I further release Georgia Youth ChalleNGe from any and all liability, claims, demands or actions, or causes of action whatsoever, arising out of any damage, loss or injury I might incur while participating in any of the activities contemplated by this mentoring agreement, whether such damage, loss, or injury is caused by the negligence of Georgia Youth ChalleNGe, its officers, agents, servants, employees, or otherwise.

Mentor's Signature \_\_\_\_\_ Date \_\_\_\_\_



NAME OF THE STUDENT I WISH TO MENTOR: \_\_\_\_\_

## Mentor Authorization to Release Information

I, \_\_\_\_\_, hereby authorize the Georgia Youth ChalleNGe Program, along with law enforcement departments, to conduct whatever background search that may be deemed appropriate.

This information is necessary to assist in determining my qualifications and suitability for the mentoring position I am seeking with the Georgia Youth ChalleNGe Program.

I fully understand that the information collected may be of a sensitive, confidential, and privileged nature, and may reflect upon my suitability. I hereby release the Georgia Youth ChalleNGe Program and its agents from the liability and damage that may result from the exchange of requested information between law enforcement departments and the Georgia Youth ChalleNGe Program.

Full name \_\_\_\_\_ Ethnicity \_\_\_\_\_

Any other name used \_\_\_\_\_

Date of birth \_\_\_\_\_ Gender \_\_\_\_\_

Place of birth \_\_\_\_\_

Social Security Number (Last Four Numbers Only) \_\_\_\_\_

Length of time lived in this state \_\_\_\_\_

State where you used to live \_\_\_\_\_

Signed \_\_\_\_\_

Dated \_\_\_\_\_

**For Official Use Only:**

Verified through GCIC \_\_\_\_\_

Date \_\_\_\_\_



# Georgia Youth Challenge Program

## Academic/Educational Services Records Request

To assist in the determination of participation in the **Georgia Youth Challenge Program**, an applicant's academic and educational records must be obtained from the previous school.

**These records are for REVIEW PURPOSES ONLY.** Once it is determined a student is accepted in the **Georgia Youth Challenge Program** and continuing their high school education in partnership with Foothills Education Charter High, a follow up verification of enrollment form will be sent.

PLEASE PRINT  
Current/Last School Attended

School Name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Exact 9<sup>th</sup> Grade Entry Date \_\_\_\_\_

Have you withdrawn from school?  Yes  No If yes, month and date of withdrawal \_\_\_\_\_

**PLEASE RELEASE RECORDS FOR REVIEW ONLY-DO NOT COUNT AS A TRANSFER**

Applicant Name: \_\_\_\_\_  
FIRST Middle Last

Date of Birth: \_\_\_\_\_ Gender:  Male  Female Grade: \_\_\_\_\_

As applicable, please provide the following:

- \*Academic Transcripts
- \*Attendance Records
- \*Standardized Test Scores (including EOC scores, EL, \*ACCESS, SAT, ACT)
- \*Discipline Records
- \*Current Class Schedule
- \*Immunization Records
- \*Hearing/Vision Screenings
- \*Gifted Records
- \*504 Services
- \*Special Education Records (including most recent psychological, most recent eligibility and IEP, initial eligibility and initial IEP)

If permitted by school district please provide the following:

Social Security Card  Birth Certificate

Please accept this document as authorization to release all official school records.

Applicant signature (over 18): \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Send all requested documents to the campus to which the applicant is applying to enroll.**

<u>Fort Stewart Campus:</u>	<u>Fort Gordon Campus</u>
Georgia Youth Challenge Program	Georgia Youth Challenge Program
Building 13540, P.O. Box 3610	Building 40006, P.O. Box 7620
Fort Stewart, Georgia 31315	Fort Gordon, Georgia 30905
or Fax them to 912-876-1764	or Fax them 706-791-5979
or e-mail them to: <a href="mailto:david.johm@gaycp.org">david.johm@gaycp.org</a>	or e-mail them to: <a href="mailto:jefferey.helms@gaycp.org">jefferey.helms@gaycp.org</a>