APPLICATION INSTRUCTIONS- READ CAREFULLY

The following materials must be filled out completely and turned in by the given deadline. Incomplete applications will not be accepted. You may use a phone to take pictures of the required documents and submit them via email as an attachment. Email all documents to admissions@sunburstyouthacademy.com

PLEASE COLLECT THE FOLLOWING ITEMS AND SUBMIT PRIOR TO October 1st, 2020:

- ❑ **Recommendation Letter (provided by school official such as school Counselor or Principal)**
- ❑ **High School Transcripts 9th grade to current year (unofficial are acceptable, parent portal)**
- ❑ **Attendance (most current school year)**
- ❑ **Behavioral Records (most current school year)**
- ❑ **IEP and TRI (only if applicable, must be current and include Psycho-Educational Report)**

- ❑ **Power of Attorney (Notarized)**
- ❑ **Legal Supporting Documents / Probation forms (if applicable)**
- ❑ **Request for release of Juvenile Court records (only if applicable)**

- ❑ **Immunization Record** (Tdap, MCV4, Meningococcal Group B, HPV, MMR, TB Test-Within 1-year, Seasonal Flu)
- ❑ **Sports Physical Form, 2 pages**
- ❑ **TB Test Result Form**

- ❑ **Birth certificate**
- ❑ **Social Security Card**
- ❑ **Health Insurance Card**
- ❑ **California ID/ Receipt * (contingent upon DMV re-opening)**

- ❑ **Custody Documents (if applicable)**

Recommendation Letter

Please have your SCHOOL PRINCIPAL, VICE-PRINCIPAL or COUNSELOR complete this form.

APPLICANT'S NAME_____
Last **First** **Middle**

TO BE FILLED OUT BY PERSON MAKING RECOMMENDATION:

Name:_____ **Title/Position:**_____

Phone: (_____) _____ **Ext:** _____ **E-Mail:**_____

School District:_____ **School Name:**_____

School Address:_____

Your recommendation of this youth to the Sunburst Youth Academy is an important element of the application package. Please tell us why you believe Sunburst Youth Academy will help this applicant educationally, and why he/she is at risk of dropping out or not graduating. (If more room is needed, please use the back of this form)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

How many credits is the student deficient? _____ **Does this student have an IEP or 504 plan? YES** ☐ **NO** ☐

Would you be interested in having a tour of the Sunburst Youth ChalleNGe Academy for you and your school staff? YES ☐ **NO** ☐

Would you consider being a mentor or secondary mentor for this youth? YES ☐ **NO** ☐

Would you consider being a mentor for a future cadet? YES ☐ **NO** ☐

A few hours a month is all it takes to be a mentor. If you would like more information, contact the Mentor Coordinator at 1-877-463-1921.

➔ **Signature of individual making recommendation:** _____**Date**_____

Sunburst Youth Academy

Special Power of Attorney for the Authorization of Medical Care and Medical Expense Statement
THIS FORM NEEDS TO BE NOTARIZED

KNOWN ALL MEN/WOMEN BY THESE PRESENTS:

That I_____, Date of birth ____/____/____ ID # _____
Guardian (or Applicant if 18 years old) *(Guardian's, or Applicant's if 18 years old, identification number)*

am a legal resident of_____ County, California, hereby appoint the director of Sunburst Youth
(Name of County)
Academy, located at Los Alamitos Joint Forces Training Base, Los Alamitos, CA, as my true and lawful attorney-in-fact to do the following in my name and in my behalf:

Anything necessary to maintain (my health) the health of my child*, _____. I want my attorney-in-fact to
***If 18 years old enter "N/A".**
have the power to consent to any medical or dental treatment needed for my child and to sign any papers needed to authorize those treatments. I want my attorney-in-fact to be able to do anything I could do if I were personally present. Anything my attorney-in-fact does to maintain the health of my child (my health) will be the same as if I had done it myself. This is a Durable Power of Attorney. It will stay in effect if I become disabled, incapacitated or incompetent. This Power of Attorney shall expire after the 22 week residential phase is completed or the Cadet withdraws or is terminated from the Academy.

Medical Expenses Statement of Understanding

The medical staff at the Sunburst Youth Academy consists of a Medical Doctor, P.A, and RNs. They will make all necessary medical determinations regarding current cadets. Sunburst Youth Academy **DOES NOT** pay for normal medical expenses incurred by your cadet. The cadet, and ultimately the parent/guardian, regardless of insurance coverage, is responsible for all normal medical and dental expenses, to include all co-payments, deductibles, and all non-covered charges. The Academy will provide physician, hospital, or pharmacy needs with the appropriate insurance information or Medical or Medicaid coverage.

IN WITNESS WHEREOF, I have affixed my signature hereto this _____day of _____20_____

➔ **Signature**_____
Guardian (or Applicant if 18 years old)

********** TO BE COMPLETED BY NOTARY **********

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

STATE OF CALIFORNIA, COUNTY OF _____)

On _____ before me, _____,

personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS My hand and official seal.

➔ **Signature: _____ (Seal)**

Sports Physical Form Page 1 of 2

SPORTS PHYSICAL FOR APPLICTION TO ATTEND SUNBURTS YOUTH ACADEMY AND IMMUNIZATION UPDATE REQUIRED

Note: this information is for official and medically confidential use only and will not be released to unauthorized persons.

Name of Student (Last, First, Middle)			Social Security Number		Date of Exam	
Street Address			City		State	Zip Code
Date of Birth	Sex	Age	Height (in.)	Weight (lb.)	Blood Pressure	
Food Allergies _____ _____	Type of Allergic Reaction		Medication Allergies _____ _____	Type of Allergic Reaction		
If History of Asthma, is inhaler and or medication Needed (If YES, aero chamber must be prescribed) YES ☐ NO ☐ NA ☐						
Current Medication _____ _____ _____ _____ _____ _____			Dosage _____ _____ _____ _____ _____ _____		Route _____ _____ _____ _____ _____ _____	

Immunizations

Please provide a copy of student's updated immunization record. Student **MUST** have the following immunizations for admittance into the Sunburst Youth Academy

Tdap (Adacel within 10 years)
Meningococcal Group B
MMR#1
HPV#1
Seasonal Flu
MCV4 Booster
MMR #2
HPV#2

TB Test (TB must be administered after December 1st, 2019)

Name of Student (Last, First, Middle)

Sports Physical Form Page 2 of 2
Past and Current Medical History

Check Yes or No. If Yes, write year and have physician explain.

	Yes	No	Year		Yes	No	Year		Yes	No	Year
Asthma				Thyroid trouble or goiter				Gall bladder trouble or gallstones			
Shortness of Breath				Eating disorder				Jaundice or hepatitis			
Pain or pressure in chest				Recent gain or weight loss				Skin disease			
Chronic Cough				Swollen or painful joints				Tumor, growth, cyst, cancer			
Palpitation or pounding heart				Arthritis, rheumatism, or bursitis				Radiation therapy or chemotherapy			
Heart trouble				Bone, joint, deformity				Hernia			
High or low blood pressure				Loss of finger or toe				Hemorrhoids or rectal disease			
Frequent or severe headaches				Painful or "trick" shoulder or elbow				Frequent or painful urination			
Dizziness				"Trick" or lock knee				Bed wetting since age 12			
Fainting spells				Recurrent back pain or any back injury				Kidney stone or blood in urine			
Head injury				Wear a brace or back support				Diabetes Type I or II			
Sinusitis				Cramps in your legs				Loss of memory or amnesia			
Wear corrective lenses				Foot trouble				Periods of unconsciousness			
Eye surgery to correct visions				Plate, pin, or rod in any bone				Sleepwalking			
Lack of vision in either eye				Nerve injury				Frequent trouble sleeping			
Eye trouble				Paralysis (including infantile)				Psychiatric issues			
Wear a hearing aid				Epilepsy or seizure				Depression			
Hearing loss				Car, train, sea or air sickness				Suicide Attempt			
Recurrent ear infections				Frequent indigestion				Broken bones			
Severe tooth or gum trouble				Stomach, liver, or intestinal trouble				Hospitalizations			

Clearance

Student can fully participate at Sunburst Youth Academy without any physical restrictions:

YES ☐ **NO ☐**

If NO, Explain:

Typed or Printed Name of Physician (Must be MD, DO, PA, NP)	Signature	Date
Stamp of Examining Facility		

TB Test Result Form

Name: _____

DOB: _____ SEX: Male / Female

To be completed by the Physician:

Name of who read the exam (please print): _____

Date TB test was administered: _____

Date TB test result was read: _____

Result of Test: _____Positive _____Negative

Does Patient need a chest x-ray? _____Yes _____No

Signature (print name and title): _____ Date: _____

MD Stamp:

Please attach form if taken within the last 12 months: