## 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 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 HEATH 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, pleaseexplain:

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

Mental Health Provider/PhysicianSignature_____

Date:_____