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THERAPIST CLEARANCE INSTRUCTIONS

Parents/Guardians,

Please present this letter and the PSYCHOTROPIC MEDICATION CLEARANCE form to your Therapist/Psychiatrist in order for them to assist you in securing the documents needed to be considered for the Sunburst Youth ChalleNGe Academy.

The client presenting this letter is now "applying" to the Sunburst Youth ChalleNGe Academy Program and the on-site high school for a period of 5 ½ months (July-Dec or Jan-June). This is an intervention and will be a temporary school assignment for students 16-18 years of age. Receipt of these documents does not mean the applicant is accepted at this time.

Please provide the client with a letter completely detailing the requirements listed below so that he/she can turn it in as part of their application:

- ☐ Client's current diagnosis
- ☐ Client's former diagnosis(es), if applicable
- ☐ The treatment plan for the client (to include: frequency of sessions, goals, client's progress, etc.)
- ☐ Any corresponding psychiatric services (to include: Psychiatrist's name/contact information, current medications and dosage, history of medication management/client's responsiveness to medication, etc.)
- ☐ Treating Therapist/Psychiatrist's professional opinion on the mental/emotional stability of the client and his/her ability to complete this program (Note: this program is a 5 ½ month, quasi-military structured program, with strict adherence to discipline/rules/order and encompasses a high-stress environment).

***Note:** If the client has ever been admitted to a hospital for behavioral health reasons, a complete psychological evaluation from the time of the hospitalization will be required IN ADDITION TO the letter provided by the current treating Therapist/Psychiatrist.

If you have any questions or need clarification regarding the Academy review process related to behavioral health only, please contact the counseling department by email at medina@sunburstyouthacademy.com.

Sincerely,

Counseling Department
Sunburst Youth ChalleNGe Academy

This information is for official and medically-confidential use only and will not be released to unauthorized persons.

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PSYCHOTROPIC MEDICATION CLEARANCE

Applicant's Name_____
Last First

PSYCHOTROPIC MEDICATION PROVIDER'S CONTACT INFORMATION:

Provider Full Name_____

Provider Address_____

Phone (_____) _____ Ext: _____

Email_____

Current prescribed psychotropic medications. If NO medications, enter N/A or NONE.

Medication	Dose	Frequency taken	Reason for taking	Dates taken: (example: Jan 2015-Feb 2020)

Medication Prescriber Signature_____**Date:**_____

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