The intent of this information is to provide the Capital Guardian Youth Challe***NG***e Academy health care personnel the background to provide appropriate care.

Name: _____ DOB: _____ Age: _____ Gender: Male Female

Home Address: _____
Street Address City State Zip Code

Parent/Guardian: _____ Phone: _____

Mental Health History

In the past, was the participant diagnosed or treated for any mental health disorder? Yes No

If yes, details on diagnoses and treatment: _____

_____

Has the participant received a PHQ9 assessment to determine his or her mental state status? Yes No

If yes, the score and conclusion: _____

_____

Current Mental Health Status

Does the participant currently have a mental health disorder? Yes No

If yes, diagnoses: _____

Is the participant currently receiving any mental health treatment (psychotherapy or medication)? Yes No

If yes, please provide details on the type of treatment: _____

_____

Is the participant mentally cleared to participate in the Capital Guardian Youth Challe***NG***e Academy?

Yes No Yes, pending _____

Signature of Licensed Medical Personnel: _____ Date: _____

Printed Name: _____

Title: _____

Address: _____

Phone Number: _____