



For Staff Only:

MEDICAL FORM

This medical form is confidential and will only be viewed by ITE Staff. Over the years, many students with a variety of medical/psychological challenges have successfully participated in our programs, however we must be aware of medical conditions in order to offer quality care and support. Failure to disclose such information could result in serious harm to the participant or fellow participants.

Participant Information

Name _____	Pronouns _____	Preferred Language _____
Date of Birth (Mo/Day/Year) _____	Sex Assigned at Birth (optional) <input type="checkbox"/> Intersex <input type="checkbox"/> Female <input type="checkbox"/> Male	
Cell # _____	Other # _____	Email _____
Address _____	Apt. _____	City/State/Zip _____

Parent/Guardian (if participant is under 18)

Name _____	Relationship _____	Preferred Language _____
Cell # _____	Other # _____	Email _____

Emergency Contact (if other than parent/guardian)

Name _____	Relationship _____	Preferred Language _____
Cell # _____	Other # _____	Email _____

COVID-19 Vaccination Status

<input type="checkbox"/> Vaccinated	<input type="checkbox"/> Unvaccinated	Number of Doses Received _____	Date of last Dose (mo/year) _____
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Health Profile (check all that apply)

<input type="checkbox"/> Allergies	<input type="checkbox"/> Bleeding or Blood Disorder	<input type="checkbox"/> Orthopedic (Bone/Joint) Issues
<input type="checkbox"/> Asthma	<input type="checkbox"/> Cardiac Issues	<input type="checkbox"/> Seizure Disorder/Epilepsy
<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Learning Difference	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Medication	

If you checked any of the boxes above, please explain in the next section.



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Health Profile Details *If you checked any boxes in the Health Profile section on the previous page, provide more details here.*

Examples: medications (prescribed & over the counter) including inhalers, severe food or insect bites/stings allergies, mental health, ADHD, recent injuries or surgeries, and/or any other relevant medical and/or mental/emotional concerns

Food intolerance / Dietary preferences? No Yes

If yes, please explain: _____

Can the participant swim? No Yes *Rate the level of swimming proficiency: (1 = beginner to 5 = competitive)* _____

Is there anything else ITE should know regarding your health? No Yes

If yes, please explain: _____

Consent is hereby given for the participant to attend ITE programs. In case of emergency, permission is given for any anesthesia, operation, hospitalization or other treatment that may become necessary.

Participant Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

(if participant is under 18)