T BAR M CHALLENGE COURSE PROGRAMS MEDICAL QUESTIONNAIRE

To be filled out by parent or guardian:
Name of student: ____________________________ Sex: ________
Birthdate: _ _ / _ _ / _ _ _ _ Social Security Number: _ _ _ - _ _ - _ _ _ _
Home Address: ____
City: __________________________ State: ___________________ Zip: __________

In an emergency notify: ____________________________ Phone: ( ) ___________
Relation to student: ______________________________
Name: ____ Phone: ( ) ___________
Relation to student: ______________________________

I understand a reasonable effort will be made to contact parents or guardians of the student. In the event I cannot be reached, I hereby give permission to the physician selected by the director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child, named above.

Signature: __________________________

Date: __________________
Day Phone: ( ) __________
Night Phone: ( ) __________

Immunizations:

DPT Booster: ________
Polio: _________
Mumps: _________
Measles: _________
Rubella: _________

Medical History
Known diseases or conditions: Asthma, heart, kidney, epilepsy, diabetes, anemia, lungs, allergies:
____

Difficulties: Nose bleeds, sore throats, colds, bed-wetting, other: ___________________________
Physical handicaps or deformities: ____
Is the student taking medication? ______ Type: ________________ How often: _________
Dosage: ________

Are you sending a prescription to T Bar M? yes no

While at T Bar M, your child will be covered under an insurance policy that will pay up to $250 non-duplication for any accident or illness that is course related. However, in the event you child is in need of medical attention due to an illness unrelated to the course, (i.e. appendicitis, dental problems, and illnesses he/she brought with them, etc.) please be advised that it is not covered by the policy. He/she will, of course, receive prompt medical attention any time it is needed, for any reason. Is the child covered under hospitalization insurance? If so,

Carrier: ______________________________ Policy Group Number: ___________________________

Name of family physician: ___________________________
Phone number: ________________________________

Parent or Guardian: ________________________________ Date: ______________________

Additional Information or Comments:
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