T BAR M CHALLENGE COURSE PROGRAMS MEDICAL QUESTIONNAIRE

To be filled out by participant:

Name of participant: _____ Sex: _____
Birthdate: _____ Social Security Number: _____
Home Address: _____
City: _____ State: _____ Zip: _____

In an emergency notify: _____ Phone: ( ) _____
Relationship: _____
Name: _____ Phone: ( ) _____

MEDICAL HISTORY (Circle appropriate answer and explain all YES answers. Attach additional sheets if necessary.)

Are you currently pregnant? YES NO
Have you had or do you currently have any heart problems (dates):
_____ YES NO
Do you frequently suffer from pains in your chest: _____ YES NO
Do you often feel faint or have spells of severe dizziness: _____ YES NO
Has a doctor ever told you that you have high blood pressure: _____ YES NO
Are you a smoker: _____ YES NO
Do you have arthritis joint of back problems that might be aggravated by exercise: _____ YES NO
_____
Have you had any operations or serious injuries (dates):
_____ YES NO
Do you have any disabilities or chronic recurring illnesses:
_____ YES NO
Are there any activities to be limited / discouraged by physicians advice:
_____ YES NO
Are you allergic to any medicines, insects or pollen:
_____ YES NO
Do you have Epilepsy: _____ YES NO
Do you have Diabetes: _____ YES NO
Do you have any prescribed meal plan or dietary restrictions: _____ YES NO
Are you currently sick and / or using a medication that's not listed above:
_____ YES NO
Additional Information or Comments: _____
_____
_____

While at T Bar M, you 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 are in need of medical attention due to an illness unrelated to the course, (i.e. appendicitis, dental problems, and illnesses you brought with you, etc.) please be advised it is not covered by the policy. You will receive prompt medical attention any time it is needed, for any reason. Are you covered under hospitalization insurance? If so:

Carrier _____ Policy # _____

In the event that I am unable to grant permission, I do give permission to the physician selected by the director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for me.

Participant's Signature: _____ Date: _____