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 answers if necessary.)

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, or 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 physician's 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.

Participants Signature: _____ Date: _____