

# 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: \_\_\_\_\_ Immunizations:  
Date: \_\_\_\_\_ DPT Booster: \_\_\_\_\_  
Day Phone: ( ) \_\_\_\_\_ Polio: \_\_\_\_\_  
Night Phone: ( ) \_\_\_\_\_ 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:  
\_\_\_\_\_  
\_\_\_\_\_