Medical Questionnaire

To be filled out by participant or parent/guardian if under 18:

Name of participant: _____

Sex: _____ Birthdate: _ _ / _ _ / _ _ _ _

Home Address: _____City: _____ State:_____ Zip: _____

In an emergency notify: _____ Best Contact Number: (____)_____

Relationship: _____

Participant Medical History – *Circle the appropriate response and describe **YES** answers in space provided*

Have you had or do you currently have any heart problems including strokes, heart attacks, and/or heart related diseases? _____ YES NO

Do you frequently suffer from pains/pressure 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

(NOTE: If you have had any heart related problems, you will need to have a release statement from a physician in order to participate in activities.)

Do you have arthritis, joint or back problems that might be aggravated by exercise? _____ YES NO

_____

Have you had any operations, serious injuries or illnesses? _____ YES NO

(dates)_____

Do you have any disabilities or communicable diseases? _____ YES NO

Are you allergic to any medicines, insects or pollen? _____ YES NO

Are you allergic to any foods? _____ YES NO

Do you have Asthma? _____ YES NO

Do you have Epilepsy? _____ YES NO

Do you have Diabetes? _____ YES NO

Do you have any prescribed meal plan or restrictions? _____ YES NO

Are you currently sick and/or using a medication not listed above? _____ YES NO

List any activities to be limited or prohibited:

_____

Suggestions or health related information T Bar M Camps & Retreats personnel should know?

_____

General Health Statement: ***How is your health today?***

_____

Additional Information or Comments:

_____

_____

Are you covered under hospitalization insurance? YES NO

Carrier_____ Policy # _____

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

Participant Name: _____

Participant/Parent Guardian Signature: _____**Date**: _____