B THE DIFFERENCE™
THE BRANDON MERRITT CHARITABLE FOUNDATION

B Happy Questionnaire

Name of Recipient: _____

Age: _____ Date of Birth: _____ Sex: M_____ F_____

Recipient E-mail address: _____

Recipient Cell Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Health Insurance (Please attach a copy of insurance card or other proof of coverage):

Name of carrier: _____

ID #: _____ Group #: _____

General Concerns/Assistive Needs: (Please Explain)

Please list any allergies: _____

_____

Mobility: _____

Physical Limitations: _____

Dietary Restrictions: _____

Communication:(Please check all that apply) ___ Good ____ Shy ____ Limited Conversation

Please explain in detail any other special assistance the recipient may need other than those already identified:

_____

_____

_____

Medical Personnel: Please review the information above and complete the section below.

"I have reviewed the information above and have discussed the B Happy trip with _____ and his/her parent(s)/guardian(s). It is of my opinion that the individual is physically and emotionally fit to participate in this B Happy trip."

Name of licensed provider: _____ Title:_____

Office Address: _____

City: _____ State: _____ Zip Code:_____

Telephone: _____

Signature: _____ Date: _____