



Sisters Under Sail Registration & Medical Information Form

Last name of student: _____

DATES

Please select your 2010 passage:

<u>DATES</u>	<u>LEG</u>
<input type="checkbox"/> May 23 - May 28	<u>Gloucester to Rockport, Maine</u>
<input type="checkbox"/> May 30 - Jun 4	<u>Rockport to Halifax</u>
<input type="checkbox"/> Jun 6 - Jul 3	<u>Halifax to Toronto</u>
<input type="checkbox"/> Jul 3 - Jul 16	<u>Toronto to Toronto</u>
<input type="checkbox"/> Jul 18 - Jul 23	<u>Toronto to Detroit</u>
<input type="checkbox"/> Jul 25 - Jul 30	<u>Detroit to Port Colborne</u>
<input type="checkbox"/> Jul 31 - Aug 15	<u>Port Colborne to Green Bay</u>
<input type="checkbox"/> Aug 15 - Aug 24	<u>Green Bay to Chicago</u>
<input type="checkbox"/> Sept 1 - Sept 4	<u>Chicago to Mackinaw City</u>
<input type="checkbox"/> Sept 5 - Sept 10	<u>Mackinaw City to Erie</u>

PAYMENT INFORMATION

PAYMENT IN IS REQUIRED IN FULL AT THE TIME OF REGISTRATION.

PLEASE MAKE CHECKS PAYABLE TO SISTERS UNDER SAIL.

Send payment and other documentation to:

**Sisters Under Sail
c/o Tallship Unicorn
2 Gravel Hill Road
Asbury, NJ 08802**

TO PAY BY CREDIT CARD, PLEASE CALL

Dawn Santamaria

908 713 1808



TRAINEE and INTERN INFORMATION

TRAINEE/INTERN NAME: _____

NICKNAME: _____

DATE OF BIRTH: / / CURRENT AGE:

GOING INTO GRADE:

CITIZENSHIP: _____ (NON-US RESIDENTS MUST PROVIDE BIRTH CERTIFICATE OR VALID PASSPORT)

- Passport issued in what country _____
- Passport number _____

PARENTS/LEGAL GUARDIANS INFORMATION

PARENTS/LEGAL GUARDIAN NAME: _____

ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____ WORK: _____

FAMILY EMAIL ADDRESS: _____

IN CASE OF EMERGENCY: _____ RELATIONSHIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK: _____



HEALTH AND MEDICAL CARE RELATED INFORMATION

HEALTH INSURANCE CARRIER: _____

NAME OF INSURED: _____

GROUP #: _____

ID#: _____

A FRONT AND BACK COPY OF INSURANCE CARD MUST ACCOMPANY THIS FORM

PHYSICIAN'S NAME: _____ PHONE: _____

PHYSICIAN'S ADDRESS: _____

DATE OF LAST PHYSICAL: _____

DENTIST'S NAME: _____ PHONE: _____

DENTIST'S ADDRESS: _____

TRAINEE/INTERN'S/INTERN'S WEIGHT _____ HEIGHT _____

HAS THIS TRAINEE/INTERN HAD ANY OF THE FOLLOWING?

ASTHMA ___ HEPATITIS ___ MIGRAINE ___ DIABETES ___ EPILEPSY OR SEIZURES ___ DIZZINESS/FAINTING ___

SINUSITIS ___ HEART CONDITION ___ CHICKEN POX ___ MUMPS ___ EARACHES ___ SKIN CONDITION ___

SEVERE STOMACH ACHES ___ SLEEP WALKING ___ MENSTRUAL CRAMPS ___

ARE THERE ANY OTHER HEALTH PROBLEMS THAT WE SHOULD KNOW ABOUT?

IS THIS TRAINEE/INTERN AFRAID OF HEIGHTS? YES ___ NO ___ NOT SURE ___

CAN THIS TRAINEE/INTERN SWIM? YES ___ NO ___ COMMENTS

DOES THIS TRAINEE/INTERN HAVE NORMAL HEARING? YES ___ NO ___

IF NO, DOES THE TRAINEE/INTERN USE A HEARING AID? YES ___ NO ___



DOES THIS TRAINEE/INTERN HAVE NORMAL VISION WITH OR WITHOUT CORRECTIVE GLASSES OR CONTACT LENSES? YES ___ NO ___

DOES THIS TRAINEE/INTERN WEAR EYEGLASSES? YES ___ NO ___

DOES THIS TRAINEE/INTERN WEAR CONTACT LENSES? YES ___ NO ___

IS THIS TRAINEE/INTERN FULLY IMMUNIZED? YES ___ NO ___

DATE OF LAST TETANUS: _____

DOES THIS TRAINEE/INTERN HAVE ANY ALLERGIES? PLEASE LIST ANY KNOWN ALLERGIES AND IDENTIFY ANY HISTORY OF SERIOUS ALLERGIC REACTIONS:

DOES THIS TRAINEE/INTERN HAVE ANY SPECIAL DIETARY NEEDS?

DOES THIS TRAINEE/INTERN REQUIRE ANY REGULAR MEDICATION OR MEDICAL TREATMENT?

NOTE: ALL MEDICATION, PRESCRIPTION AND NON-PRESCRIPTION, ARE GIVEN TO THE CAPTAIN FOR SAFEKEEPING. WRITTEN INSTRUCTIONS MUST ACCOMPANY SUCH MEDICATIONS SO THAT THEY MAY BE GIVEN TO THE TRAINEE/INTERN AS REQUIRED.

OTHER NOTES



Sail training courses are physically demanding. Our 118-foot topsail schooner operates in all weather, 24 hours a day. TRAINEE/INTERNS live in close quarters and are encouraged to participate in all ship routines and program activities (swimming, keeping watch, going aloft, performing emergency drills, maintenance work, etc.) It is essential for the safety of the TRAINEE/INTERN and the total ship's company that your son/daughter/ward be medically and psychologically fit.

Our ship is supplied with first aid equipment and our officers are certified to deliver emergency first aid. We also have satellite telephones and cellular phones aboard which allow us to communicate with medical personnel, if required. Nevertheless, **it is important to recognize that our ship is sometimes many hours away from acute care medical services.** If your son/daughter/ward/ has a pre-existing condition (diabetes, asthma, seizure disorder, etc.) which may require emergency care during a course, please consult your physician and disclose the condition (see below) before signing this release.

It is the policy of Sisters Under Sail to control the use of all medications (prescription and/or non-prescription) while your child is aboard ship. Therefore, all medications are to be placed in a labelled Ziploc baggie with instructions from you, her legal guardian. We do dispense seasickness medication as needed.

I have read the information above and completed the medical information form. To the best of my knowledge, my son/daughter/ward is in good health and able to participate fully in Sisters Under Sail's youth sail training program. I give my permission for Sisters Under Sail to contact the physicians named above if more medical information is required. In case of a medical emergency, I give my permission for the employees and agents of Sisters Under Sail to administer first aid, and if I am not available for consultation, to select a physician who will secure proper medical treatment (including examination, medication, treatment, anaesthesia or surgery) for my above named son/daughter/ward.

By signing this document I, _____ (parent/legal guardian of TRAINEE/INTERN), acknowledge that I have read and have provided accurate information regarding the TRAINEE/INTERN. I also acknowledge that I have read and understand the Sisters Under Sail Handbook.

DATE: _____ PARENT/GUARDIAN SIGNATURE: _____

I, _____ (TRAINEE/INTERN), acknowledge that I have read and understand the Sisters Under Sail Handbook.

DATE: _____ TRAINEE/INTERN SIGNATURE: _____