HEALTH AND MEDICAL CARE RELATED INFORMATION

CIRCLE YOUR TRICARE PROVIDER: HEALTHNET HUMANA TRIWEST

ACCOUNT HOLDER: ____

ID#: ____

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

PRIMARY CARE PHYSICIAN'S NAME: ____

PHONE: ____

PHYSICIAN'S ADDRESS:

____

DATE OF LAST PHYSICAL: __________________________________

IS THIS TRAINEE FULLY IMMUNIZED? YES ___ NO ___

DATE OF LAST TETANUS: ______________________________

DENTIST'S NAME: ____PHONE: _______________________

DENTIST'S ADDRESS: ____

1. TRAINEE WEIGHT ________ HEIGHT ________
2. HAS THIS TRAINEE HAD ANY OF THE FOLLOWING?

ASTHMA ___ HEPATITIS ___ MIGRAINE ___ DIABETES ___ EPILEPSY OR SEIZURES ___

DIZZINESS/FAINTING ___SINUSITIS ___ HEART CONDITION ___ CHICKEN POX ___ MUMPS ___ EARACHE ___

SKIN CONDITION ___SEVERE STOMACH ACHES ___ SLEEP WALKING ___ MENSTRUAL CRAMPS ___

3. ARE THERE ANY OTHER HEALTH RELATED ISSUES THAT WE SHOULD KNOW ABOUT?

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4. IS THIS TRAINEE AFRAID OF HEIGHTS? YES ___ NO ___ NOT SURE ___
5. CAN THIS TRAINEE SWIM? YES ____ NO ____ COMMENTS __________________________________
6. DOES THIS TRAINEE HAVE NORMAL HEARING? YES ___ NO ___

   IF NO, DOES THE TRAINEE USE A HEARING AID? YES ___ NO ___
7. DOES THIS TRAINEE HAVE NORMAL VISION WITH OR WITHOUT CORRECTIVE GLASSES OR CONTACT LENSES? YES ___ NO ___
8. DOES THIS TRAINEE HAVE ANY ALLERGIES? PLEASE LIST ANY KNOWN ALLERGIES AND IDENTIFY ANY HISTORY OF SERIOUS ALLERGIC REACTIONS:

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9. DOES THIS TRAINEE HAVE ANY SPECIAL DIETARY NEEDS?

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10. DOES THIS TRAINE REQUIRE ANY REGULAR MEDICATION OR MEDICAL TREATMENT?

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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 AS REQUIRED.**

Sail training courses are physically demanding. Our 110-foot topsail schooner operates in all weather, 24 hours a day. TRAINEE 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 and the total ship's company that your 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 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 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), acknowledge that I have read and have provided accurate information regarding the TRAINEE.

PARENT/GUARDIAN SIGNATURE:
____

DATE: __________________