MEDICAL INFORMATION FORM

This form must be completed and signed by a physician for participants of all offshore trips, and for near-coastal trips if you answer 'yes' to any of the questions. For any 'yes' items, please include a brief written explanation on another sheet of paper and attach it to this form.

Participant's Full Name ______________________ DOB (mm/dd/yy) ______________________

Age ______________ Height (ft) ____________ Weight (lbs) ____________ Blood Type ______

1. Have you ever had or do you currently have the following:

Yes	No		Yes	No		Yes	No	
☐	☐	Inability to perform moderate exercise	☐	☐	Any type of hernia	☐	☐	Asthma
☐	☐	Irregular heart beat	☐	☐	Ear disease, hearing loss	☐	☐	Lung disease
☐	☐	Bleeding or blood disorder	☐	☐	Back or neck problems	☐	☐	Back surgery
☐	☐	Heart/Blood vessel surgery	☐	☐	Arm or shoulder problems	☐	☐	Blackouts or fainting
☐	☐	Knee or leg problems	☐	☐	Epilepsy, convulsions or seizures	☐	☐	Heart disease
☐	☐	Drug or alcohol abuse (or treatment for)	☐	☐	Diabetes (If YES, circle: TYPE 1 or TYPE 2)			

2. Are there any other medical conditions that we should be aware of?

____

3. Have you ever been hospitalized? Yes ☐ No ☐ If yes, give approximate dates and treatment rendered.

____

4. Have you ever been under the care of a psychiatrist or psychologist? Yes ☐ No ☐ If yes, please give details.

____

5. Do you take prescription medication aside from birth control? Yes ☐ No ☐ List all drugs /medications taken and condition for which taken.

____

6. Are you allergic to any medications? Specifically antibiotics, antihistamines and pain relievers (please list specific strain if necessary):

____

7. Any other allergies, specifically food (peanuts, gluten, dairy, eggs), bees, jellyfish, etc:

____

8. Date of last Tetanus inoculation or booster______________ 9. Date of last TB test : ______________

By signing this form I certify that I have answered the above medical questions to the best of my knowledge and have not omitted any information about my medical history that could have an impact on others or me during my time on the trip.

Participant Signature______________________________ **Date** ______________

Parent Signature (if under 18)__________________________ **Date** ______________

To be completed by a physician for all offshore trips and for near-coastal trips if answering Yes to any of the questions above:
This participant is enrolling for a sailing program involving moderate physical activity and, in many trips, may spend as many as 20-days offshore, away from any emergency medical services. In view of the above list of possible conditions and the answers thereto, this person is, in my opinion, medically fit to undertake such a program of activity.

Physician's Name ______________________________ Phone ______________

Physician's Signature ______________________________ Date ______________