MEDICAL FORM
Confidential

Instructions: Participants must have a thorough physical exam not more than 6 months prior to arrival aboard the *Spirit of South Carolina*. Participants, or guardian if participant is a minor, complete and sign Parts I and II. Physicians complete and sign Part III.

This form must be turned in to SCMF by June 3, 2011.

Part I: General Information (Completed by Participants)

Participant's Name: ______________________________ Gender: Male / Female
Last First

Birth date: ____________________ Age: ________ Prefers to be called: ____________________

Home Address: ____
Street City State Zip

Phone: ____________________ E-mail: ____________________

Person to be notified in case of illness or injury:

Name (s): ____________________ Relationship: ____________________

Address: ____

Phone #'s : ______________ or ______________ Email: ____________________
Home Work/Cell

Medical Insurance

Please complete the information below and sign if you have current medical insurance.

Insurance Company: ____________________ Policy Number: ____________________

Subscriber: ____________________ Relationship: ____________________

Family Doctor: ____________________ Phone Number: ____________________

Part II: Health History (Completed by Participants)

The following information must be filled in by the participant, parent, or guardian. The intent of this information is to provide the medical officer onboard with background to provide appropriate care. Any changes to this form should be provided to the medical officer upon participant's arrival to the ship.

General Questions: (If answered "YES" to any question below, please explain on lines provided)

1. Asthma or any respiratory problems? YES / NO
2. Diabetes? YES / NO
3. Epilepsy, seizures, fainting, or dizziness? YES / NO
4. Cardiac conditions (e.g. heart murmurs, irregular heartbeat)? YES / NO
5. Eating disorders? YES / NO
6. Pregnancy? YES / NO
7. Neck/back/shoulder/knee/ankle/wrist/hand/arm problems? YES / NO
8. Any other medical conditions that we should be aware of? YES / NO

If you answered "YES" to any of the above questions, please elaborate here:

____

____

____

Please list any additional health conditions that you would like us to be aware of, or may influence your ability to participate onboard:

____

____

____

Swimming Ability:

For your safety, it is critical that the captain of the vessel be **aware** of your swimming/floating ability.
Please let us know if you can remain afloat, unassisted, for 30 minutes: YES / NO

Allergies: List all known

Medication Allergies:	**Describe reaction and management of reaction:**
______________________	______________________
______________________	______________________

Food Allergies:

______________________	______________________
______________________	______________________

Other:

______________________	______________________
______________________	______________________

Medications:

Please list ALL medications (including over-the-counter/nonprescription drugs and birth control) taken routinely. Keep all medications in the original packaging/bottle that identifies the name of the medication, dosage, and the frequency of administration. Program policy states that ALL medications will be kept in the medical locker. The ship's medical officer, or captain will administer medications as needed. If you are prescribed an inhaler, please be sure to bring it with you.

_______This person takes NO medications on a routine basis

_______This person takes medications as follows:

Medication #1 ______________________________ Dosage _________ Times taken/day______

Reason for taking ____

Medication #2 ______________________________ Dosage _________ Times taken/day______

Reason for taking ____

Medication #3 ______________________________ Dosage _________ Times taken/day______

Reason for taking ____

Dietary Restrictions:

___ Does not eat Red Meat	___ Does not eat Pork	___ Does not eat Fish
___ Does not eat Poultry	___ Does not eat Dairy	___ Other (describe)
___ Does not eat Shellfish	___ Does not eat Eggs	__________________

IMPORTANT – this section must be completed in order to participate in the sail

I certify that this health history, and all information on it, is **complete and accurate,** and that I am physically and emotionally fit to participate in this offshore voyage. In the event of an emergency, I hereby authorize the South Carolina Maritime Foundation (SCMF), its Doctor(s), ship's Captain or Medical Officer to administer emergency medical treatment and to hospitalize, secure proper treatment for, and to order injections, anesthesia, or surgery for me. I further agree that this authorization includes the administration of all prescribed medications and treatments listed in this health history. I give permission for SCMF and its staff to share information from this form if needed for medical purposes. I understand that I am responsible for notifying SCMF of any injury, illness or other medical condition or **change** to the medical information here provided. I certify that I am at least 18 years of age. (If not 18, parent/guardian must also sign.)

____ __________________________

Printed Name of Participant Date

Signature (required): ____

Parent/Guardian must cosign for participants who are less than 18 years of age:

__________________________________ ______________________________________

(Parent/Guardian Name) (Parent/Guardian Signature)

Part III (To be Completed by Physician)

Information for the Physician. **Please read carefully:**

Spirit of South Carolina's programs involve voyages on a 140 foot sailing vessel, that may travel for multiple days before a port stop. While at sea the vessel may travel far offshore, in areas including the Eastern Seaboard, Caribbean, and the North Atlantic, where medical care is essentially **not available**.

Treatment facilities aboard consist of a modest medicine chest administered by the ship's Captain or Medical Officer. Radio contact **may** allow the Captain or Medical Officer to be guided by a physician ashore. **Medical evacuation is not possible** except in rare circumstances.

Participants stand watches around the clock, in an environment that is both physically and emotionally demanding. Seasickness, a common problem, can render oral medication ineffective or impossible.

In light of these circumstances, we request a **full disclosure** of medical problems. Given sufficient lead-time, we can frequently plan to manage a medical condition at sea. If medical problems are discovered at the last minute, it may result in a persons ineligibility to participate in this program in the interest of his/her own well-being and that of his/her shipmates.

Examination:
If any item in the **Medical History** on page 2 is checked, please comment on the specific details. We are interested in the dates of the condition(s), specific medication(s), effects of not taking the medication(s), and the current status of the condition(s). Please consider the environment described above when making your comments. **Full disclosure is critical.**

Item from page 2: Explanation:
____
____
____
____
____
____
____

Height________ Weight________ BP________ P________

General appearance and state of nutrition _______________________________________

Is the student **allergic** to any of the following (circle):
Medications (penicillin, aspirin, sulfa, etc.)
Foods (shellfish, nuts, etc.)
Insect bites, Other (wool, feathers, detergents, etc.)

If allergic, what is the reaction?____
If the student has a history of severe allergic reactions, he/she must bring at least 2 **Epipen Kits** to sea.

Please specifically evaluate tuberculosis risk factors. Include skin test and chest x-ray when indicated in your judgment and provide us with the results. With your help, we can monitor risk for our entire shipboard community:
There is no risk___________ Risk:_______________(attach documentation)

Required Immunization:
Tetanus Toxoid series. Date of last booster (within 7 years): ______________________________

Part III Continued (To be Completed by Physician) Please check if normal; describe if abnormal.

□ Skin
□ Lymph Nodes
□ Eyes
□ Ears
□ Nose
□ Mouth
□ Teeth
□ Throat
□ Neck
□ Thyroid
□ Thorax & Lungs
□ Heart
□ Abdomen

Remarks:

____
____
____

□ Extremities
□ Arms
□ Hands
□ Knees
□ Ankles
□ Feet
□ Peripheral Vessels
□ Back
□ Genitalia
□ CNS
□ Hernia
□ Scars

Remarks:

____
____
____

How long have you known this person?______________________________

Do you feel that further diagnostic examination and treatment is indicated? ______________

"I have examined this individual herein described, reviewed his/her health history, and have read the ***Information for Physician*** *(page 3). It is my opinion that he/she is physically and emotionally fit to participate in the environment described."*

NAME of licensed physician (please print):______________________________

SIGNATURE of licensed physician:______________________________

Address:______________________________

____

Telephone: ____________________ Date: ____________________

This form must be returned to:

Spirit Ocean Adventure
South Carolina Maritime Foundation
PO Box 22405
Charleston, SC 29413
843.722.1030 phone
843.722.2243 fax
marine@scmaritime.org

For Office Use Only:

Received: ____________
(date&initials)

Reviewed: ____________
(date&initials)

Cleared: ____________
(date&initials)