



SEA EDUCATION ASSOCIATION

Confidential Medical Record Form

Please check the appropriate box:

- Professional Crew
- Volunteer Crew
- Student/Participant

Program Name: _____

Class #: _____

SEA Use Only:

Cleared

By: _____

Date: _____

Instructions: A physical exam should be completed by a medical professional (MD, PA or NP) within six (6) months prior to sailing onboard an SEA ship. The exam will be valid for up to two years. **You MUST notify SEA of ANY changes in medical condition PRIOR to joining the ship.**

Part I - General Information (Completed by Participant)

Name: _____ Male _____ Female _____

Home Address: _____

Cell Phone () _____ Email Address: _____ Date of Birth: _____

PHYSICIAN:

Name: _____ Telephone () _____

Address: _____

EMERGENCY CONTACT: (Person to be notified in case of illness/injury) (Parent/Guardian if under 18 years of age)

Name _____ Relationship: _____

Address: _____

Cell Phone () _____ Other Phone () _____ Email: _____

Medical Insurance

We require that you be covered by a sickness and accident policy, which is valid in the USA and foreign countries. Please complete the information below:

Insurance Company: _____ Policy Number: _____

Subscriber: _____ Relationship to you: _____

Insurance Company's Phone # _____ Subscriber's Phone #: _____

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:

Sea Sickness: SEA ships carry meclizine and promethazine for treating seasickness. The captain may make these medications available to participants with the approval of participant's physician AND parent/guardian (if under 18).

Physician: I approve / I do NOT approve (circle one) offering the above medications to this participant for treating seasickness.

Physician signature: _____

Parent/Guardian: I approve / I do NOT approve (circle one) offering the above medications to my daughter/son for treating seasickness.

Parent/Guardian signature for student under 18): _____

Part II - Medical History (Completed by Participant)

Given the nature of the shipboard environment, it is **CRUCIAL** that you submit an **honest, accurate and complete medical history**. With sufficient lead-time, we are able to make certain accommodations for medical conditions onboard ship.

If you have had past or current history with ANY of the following, please check the appropriate box, circle and explain below.

Current	Past		Current	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Vision problems, eye disease, surgery, color blindness, glaucoma, glasses or contacts	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss, hearing aids
<input type="checkbox"/>	<input type="checkbox"/>	Dizzy spells, fainting, convulsions, seizures, vertigo	<input type="checkbox"/>	<input type="checkbox"/>	Motion/ sea sickness
<input type="checkbox"/>	<input type="checkbox"/>	Persistent headaches, migraines	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones, dislocations, sprains
<input type="checkbox"/>	<input type="checkbox"/>	Any severe injury to head, chest, or internal organs	<input type="checkbox"/>	<input type="checkbox"/>	Joint pains, swelling, stiffness, or dislocation
<input type="checkbox"/>	<input type="checkbox"/>	Frequent infection of throat, tonsils, sinuses, or ears	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain in neck, back, or limbs
<input type="checkbox"/>	<input type="checkbox"/>	Asthma, shortness of breath, chronic cough, bronchitis, tuberculosis, bloody sputum	<input type="checkbox"/>	<input type="checkbox"/>	Back Injury or surgery, ruptured/herniated disc
<input type="checkbox"/>	<input type="checkbox"/>	Heart condition, irregular heartbeat, heart palpitation, murmurs, pain or angina, heart attack, congestive heart failure, surgery, pacemaker, poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	Nerve pain or damage, sciatica
<input type="checkbox"/>	<input type="checkbox"/>	Low/high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Illness requiring hospitalization or prolonged incapacitation
<input type="checkbox"/>	<input type="checkbox"/>	Anemia, Hepatitis, Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Cramps, heat exhaustion, or other reaction to high temperatures
<input type="checkbox"/>	<input type="checkbox"/>	Frequent nausea/vomiting, food intolerances/allergies, dietary restrictions, indigestion/heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Narcolepsy, sleep apnea, restless leg, sleep walking
<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal bleeding, Crohn's Disease, Ulcerative colitis, Gallbladder stone or surgery, frequent diarrhea or bloody stools	<input type="checkbox"/>	<input type="checkbox"/>	Claustrophobia, agoraphobia, acrophobia (strong fear of confined places, open areas, heights)
<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	ADHD or ADD, Learning disability
<input type="checkbox"/>	<input type="checkbox"/>	Hypo/hyper glycemia	<input type="checkbox"/>	<input type="checkbox"/>	History of depression, anxiety, hysteria or nervousness, Post-Traumatic Stress Disorder (PTSD)
<input type="checkbox"/>	<input type="checkbox"/>	Severe menstrual cramps, frequent abdominal cramps	<input type="checkbox"/>	<input type="checkbox"/>	Continuing use of alcohol, drugs, or medicines
<input type="checkbox"/>	<input type="checkbox"/>	Urinary tract infections, painful or frequent urination, bed wetting	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy (current)
<input type="checkbox"/>	<input type="checkbox"/>	Hernia, Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	Problems with teeth.
<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones or infections, dialysis, transplant			When was your last dental exam?
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes, thyroid condition, bleeding problems, or epilepsy			_____
<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease or sexually transmitted disease			
<input type="checkbox"/>	<input type="checkbox"/>	Chronic skin problems (rash, infection)			

Did you check any boxes above? If so, please provide details of the medical condition, both past and present: _____

(Please attached a piece of paper if additional room is needed for details)

DIETARY RESTRICTION: Have you previously or do you have any dietary allergies, restrictions? Please explain: _____

Do you follow any of the following diets? VEGAN VEGETARIAN GLUTEN-FREE LACTOSE-FREE

PSYCHIATRIC/PSYCHOLOGICAL: Have you previously received or are you currently receiving, a diagnosis or treatment? If so, please print doctor's name. Also include reason, dates, and medications:

PRESCRIPTION MEDICATION(S): If you now take, usually take, or keep with you any prescription medication(s), please specify. Include dosage and purpose: _____

Authorization

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 an extended offshore voyage. In the event I cannot make a decision in an emergency, I hereby authorize the Sea Education Association, Inc. (SEA), 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 give permission for SEA staff to share information from this form if needed for medical purposes.

I understand that I am responsible for notifying SEA immediately 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.)

Participant Name (please print): _____

Participant Signature (required): _____ Date: _____

Parent/Guardian Name (if applicable) (please print): _____

Parent/Guardian Signature (if applicable): _____ Date: _____

(Parent/guardian name and signature are required for any Participant who will be less than 18 years of age at the time of sailing)

Part III (Completed by the Physician)

PHYSICIAN: Please read carefully.

SEA Semester programs involve six-week voyages on research vessels and up to 40 consecutive days on the ocean without a port stop. The 135' sailing vessels remain at sea far offshore, in areas including the Caribbean, the North Atlantic and Pacific Oceans. SEA Seminar programs involve ten-day sea components.

Medical care essentially is **not available**. Treatment facilities aboard consist of a modest medicine chest administered by the ship's Captain. Radio contact **may** allow the Captain to be guided by a physician ashore. **Medical evacuation is not possible** except in rare, fortunate 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 frequently can plan to manage a medical condition at sea. If medical problems are discovered at the last minute, it may be necessary for the Participants to leave the ship in the interest of his/her own well-being and that of his/her shipmates.

GENERAL HEALTH: Check if within normal range, describe if not.

<input type="checkbox"/> Eyes <input type="checkbox"/> Ears <input type="checkbox"/> Nose <input type="checkbox"/> Mouth <input type="checkbox"/> Teeth <input type="checkbox"/> Throat <input type="checkbox"/> Neck <input type="checkbox"/> Thyroid <input type="checkbox"/> Lymph Nodes Remarks: _____ _____	<input type="checkbox"/> Skin <input type="checkbox"/> Thorax & Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Back <input type="checkbox"/> Genitalia <input type="checkbox"/> CNS <input type="checkbox"/> Hernia <input type="checkbox"/> Scars Remarks: _____ _____	<input type="checkbox"/> Extremities <input type="checkbox"/> Arms <input type="checkbox"/> Hands <input type="checkbox"/> Knees <input type="checkbox"/> Ankles <input type="checkbox"/> Feet <input type="checkbox"/> Peripheral Vessels Remarks: _____ _____
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Examination

In addition to your findings during this physical exam, or knowledge or any medical history of this patient, please also comment on specific details of any item in the **Medical History** on page 2 checked. 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 (inches): _____ Weight (lbs): _____ BP: _____ Pulse: _____

General appearance and state of nutrition:

Is the participant **allergic** to any of the following (circle):

Medications (penicillin, aspirin, sulfa, etc.)

Foods (shellfish, nuts, etc.)

Insect bites, Other (wool, feathers, detergents, etc.)

Other: _____

If allergic, what is the reaction?

*If the participant has a history of severe allergic reactions, he/she must bring at least 2 **Epipen Kits** to sea.*

Tuberculosis Risk Evaluation: 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. **No Risk:** _____ **Risk:** _____ (attach documentation)

Required Immunization:

Tetanus Toxoid series. Date of last booster (within 7 years): _____

How long have you known this person? _____

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

*"I have examined the participant 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: _____

Phone #: _____ Email: _____ Date: _____

This form must be returned AS SOON AS POSSIBLE for review prior to joining SEA.

**** Anyone sailing onboard an SEA vessel is subject to medical clearance. ****