Expedition Health Form | Undergraduate

Caribbean Sailing

Consent and Authorization

It is important that Wharton Leadership Ventures and its external venture providers be made aware of medical or emotional issues, past or current, as even mild physical or psychological conditions can become serious under the stresses of life in an unfamiliar environment.

The information provided by you and your physician(s) will remain confidential. By signing below, you consent to the information being shared with Wharton Leadership Ventures program staff, your venture provider, and other appropriate professionals, if pertinent to your well-being or your participation in the venture program.

You also authorize by your signature below the release of any medical information that may be relevant in the opinion of your health care provider to your participation in this external venture program.

Your Signature: _____

Date: _____

Instructions for
Sail Caribbean Medical Form

All students who participate in a Sail Caribbean adventure must complete and return the attached form to us via fax: 631-754-3362, scan and email to: info@sailcaribbean.com, or by mail to: Sail Caribbean, 256 Main St., Suite 1203, Northport, NY 11768.

SAIL CARIBBEAN MEDICAL FORM:

1. In the HEALTH EXAMINATION RECORD section answer each question by writing either the word **YES** or the word **NO** in **every** blank. (A simple **Y** or **N** in **every** blank will also suffice.)
2. If you answer **YES/Y** to any question, please provide details in the corresponding sections at the bottom of the page.
3. A doctor's signature is required in the PHYSICIAN SIGNATURE & INFORMATION section.
4. Participant must sign and date the form.

SAIL CARIBBEAN MEDICAL FORM

Please complete and return to:
Sail Caribbean 256 Main St, Suite 1203, Northport, NY 11768
Phone: 800-321-0994 or 631-754-2202 Fax: 631-754-3362
Email: info@sailcaribbean.com

THIS FORM IS REQUIRED FOR PARTICIPATION. AND M UST BE SIGNE BY DOCTOR AND STUDENT. NO OTHER MEDICAL FORM CAN BE ACCEPTED.

NAME:_____ **PROGRAM:** _____Age _____Sex_____Date of Birth (m/d/y)_____

EMERGENCY CONTACT INFORMATION:

Parent home:_____
Parent work:_____
Parent cell:_____
Other:_____

Alternate contact name:_____
Relationship:_____
Phone:_____

Student:

I hereby certify that I have read the Health Examination Record completed and signed by my physician and agree that to the best of my knowledge all information is accurate and complete. I hereby grant Sail Caribbean and its agents full authority to take whatever actions they may consider to be warranted under the circumstances regarding my health and safety; and I fully release each of them from any liability for such decisions or actions as may be taken in connection therewith. I authorize Sail Caribbean and its agents at their discretion to place me at my own (or my parent's) expense and without further consent, in a hospital for medical treatment within or outside the United States using any means of transportation necessary at my own (or my parent's) expense.

STUDENT SIGNATURE:

✖ _____ **Date:**_____

PHYSICIAN SIGNATURE & INFORMATION

I have examined _____ on_____(date) and found him/her to be in good health. Taking into account the conditions stated below, he/she can, in my opinion, fully participate in all Sail Caribbean program activities. I understand that additional forms are required to participate in SCUBA diving.

Physician's Name (Print) _____Phone No._____Fax No._____

City/State/Zip_____

PHYSICIAN SIGNATURE: ✖ _____ **Date:**_____

HEALTH EXAMINATION RECORD *(to be completed by parents in conjunction with your physician)*

Write *YES* or *NO* in each blank in response to the following questions on the participant's past and/or present medical history. **If you answer YES, please provide details of the condition(s) and management of the condition(s) in the "DETAILS" section.**

_____ Any medications? ***List below** all prescriptions, over-the-counter & vitamins
_____ Allergies to medications?
_____ Allergies/foods, insect bites, etc?
_____ Do you have a prescription for an EPI-Pen?
_____ Asthma?
_____ Any exercise induced conditions or physical limitations?
_____ Recurring headaches, fainting or loss of consciousness?
_____ Ear, eye, nose or throat conditions?
_____ Skin condition or sensitivity to daily sun and salt water?
_____ Urinary or gastrointestinal conditions?
_____ Diabetes?
_____ ADD or ADHD?

_____ High blood pressure?
_____ Heart disease or heart condition (mild or otherwise)?
_____ Epilepsy, seizures or neurological problems?
_____ Spinal or neck injuries or problems?
_____ Knee or joint injuries or problems?
_____ Surgery or significant medical procedures?
_____ Special diet requirements?
_____ Eating disorders?
_____ Behavioral or emotional problems?
_____ Learning disabilities requiring special needs?
_____ History of substance abuse?
Date of last tetanus shot:_____

PROVIDE DETAILS - *If answered YES above:*_____

☐ Check if attachment

Any Other Conditions Not Specified Above?_____

☐ Check if attachment

***MEDICATIONS** List all prescriptions, over-the-counter, vitamins, required dosages, reasons for taking, appropriate use and any special instructions below. Also indicate any recently discontinued medication._____

☐ Check if attachment

Note: If you are prescribed an EPI-Pen, or have ever needed to use one, you must bring 3 with you to the program.