Instructions for Sail Caribbean Medical Form

All students who participate in a Sail Caribbean adventure must complete this form.

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 if the participant is under 18 years of age.

4. Participant must sign and date the form.

SAIL CARIBBEAN MEDICAL FORM

Please complete and return via email to: info@sailcaribbean.com

** THIS FORM IS REQUIRED FOR PARTICIPATION AND MUST BE SIGNED BY THE STUDENT. NO OTHER MEDICAL FORM CAN BE ACCEPTED.*

NAME: _____ **PROGRAM:** _____ **AGE:** _____ **SEX:** _____

DATE OF BIRTH (MM/DD/YY): _____

EMERGENCY CONTACT INFORMATION:

Parent home: _____ Alternate contact name: _____

Parent work: _____ Relationship: _____

Parent cell: _____ Phone: _____

Student:

I hereby certify that I have read the Health Examination Record completed and signed by my physician (if under 18 years of age) 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:** _____

HEALTH EXAMINATION RECORD (to be completed by student 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

____ 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

____ 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:***	**Any Other Conditions Not Specified Above?**	***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 Check if attachment if attachments

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