



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 under 18 years of age, complete and sign Part I and Part II. Physicians complete and sign Part III.

This form must be completed and returned by June 1, 2010. If there are any changes to your medical condition after this exam, please notify SCMF.

Part I: General Information (Completed by Participants)

Participant's Name: _____
Last First
Birth date: _____ Age: _____ Gender: Male / Female
Home Address _____ City: _____
State: _____ Zip: _____ Phone: _____ E-mail: _____
Family Doctor: _____ Phone Number: _____

Person to be notified in case of illness or injury:

Name: _____ Relationship: _____
Address: _____ Phone #'s : _____ or _____
Home Work/Cell

Medical Insurance

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

Insurance Company: _____ Policy Number: _____
Subscriber: _____ Relationship: _____

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 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.

<input type="checkbox"/> Skin <input type="checkbox"/> Lymph Nodes <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"/> Thorax & Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen 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 <input type="checkbox"/> Back <input type="checkbox"/> Genitalia <input type="checkbox"/> CNS <input type="checkbox"/> Hernia <input type="checkbox"/> Scars Remarks: _____ _____ _____
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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
 c/o South Carolina Maritime
 PO Box 22405
 Charleston, SC 29413

For Office Use Only:

Received: _____
 (date&initials)

Reviewed: _____
 (date&initials)

Cleared: _____
 (date&initials)