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 6 months prior to sailing onboard an SEA ship. The exam will be valid for up to two years. If any information changes after the exam, ***you MUST notify SEA PRIOR to joining the ship or beginning your program.***

Part I - General Information (Completed by Participant)

Name: _____ Male___Female___Other____

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

You must 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 swim and/or remain afloat, unassisted, for 30 minutes: Yes: ☐ No: ☐

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

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

_____

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	
☐	☐	Vision problems, eye disease, surgery, color blindness, glaucoma, glasses or contacts	☐	☐	Hearing Loss, hearing aids
☐	☐	Dizzy spells, fainting, convulsions, seizures, vertigo	☐	☐	Motion/ sea sickness
☐	☐	Persistent headaches, migraines	☐	☐	Broken bones, dislocations, sprains
☐	☐	Any severe injury to head, chest, or internal organs	☐	☐	Joint pains, swelling, stiffness, or dislocation
☐	☐	Frequent infection of throat, tonsils, sinuses, or ears	☐	☐	Chronic pain in neck, back, or limbs
☐	☐	Asthma, shortness of breath, chronic cough, bronchitis, tuberculosis, bloody sputum	☐	☐	Back Injury or surgery, ruptured/herniated disc
☐	☐	Heart condition, irregular heartbeat, heart palpitation, murmurs, pain or angina, heart attack, congestive heart failure, surgery, pacemaker, poor circulation	☐	☐	Nerve pain or damage, sciatica
☐	☐	Low/high blood pressure	☐	☐	Illness requiring hospitalization or prolonged incapacitation
☐	☐	Anemia, Hepatitis, Jaundice	☐	☐	Cramps, heat exhaustion, or other reaction to high temperatures
☐	☐	Frequent nausea/vomiting, food intolerances/allergies, dietary restrictions, indigestion/heartburn	☐	☐	Narcolepsy, sleep apnea, restless leg, sleep walking
☐	☐	Gastrointestinal bleeding, Crohn's Disease, Ulcerative colitis, Gallbladder stone or surgery, frequent diarrhea or bloody stools	☐	☐	Claustrophobia, agoraphobia, acrophobia (strong fear of confined places, open areas, heights)
☐	☐	Eating Disorder			
☐	☐	Hypo/hyper-glycemia	☐	☐	ADHD or ADD, Learning disability
☐	☐	Severe menstrual cramps, frequent abdominal cramps	☐	☐	History of depression, anxiety, hysteria or nervousness, Post-Traumatic Stress Disorder (PTSD)
☐	☐	Urinary tract infections, painful or frequent urination, bed wetting			
☐	☐	Hernia, Appendicitis	☐	☐	Continuing use of alcohol, drugs, or medicines
☐	☐	Kidney stones or infections, dialysis, transplant			
☐	☐	Diabetes, thyroid condition, bleeding problems, or epilepsy	☐	☐	Pregnancy (current)
☐	☐	Venereal disease or sexually transmitted disease	☐	☐	Problems with teeth.
☐	☐	Chronic skin problems (rash, infection)			When was your last dental exam?
☐	☐	Concussion			_____
☐	☐	Any surgery within 1 year			

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

_____

_____

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

PSYCHIATRIC/PSYCHOLOGICAL: Have you previously received or are you currently receiving, a diagnosis or treatment? If so, please print doctor's name and contact information. 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: _____

_____

You are required to bring a 100% redundant supply of all medications with you to sea. Please work with your doctor and/or insurance to arrange this.

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 that 18 years of age at the time of enrollment)

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 participant 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.

☐ Eyes ☐ Ears ☐ Nose ☐ Mouth ☐ Teeth ☐ Throat	☐ Neck ☐ Thyroid ☐ Lymph Nodes ☐ Skin ☐ Thorax & Lungs ☐ Heart	☐ Abdomen ☐ Back ☐ Genitalia ☐ CNS ☐ Hernia ☐ Scars	☐ Extremities ☐ Arms ☐ Hands ☐ Knees ☐ Ankles ☐ Feet ☐ Peripheral Vessels

Remarks or Comments: _____

_____

SEA SICKNESS: *SEA ships carry meclizine for managing seasickness. Ondansetron and promethazine are also carried for cases where meclizine is ineffective. SEA will make every effort to make appropriate medications available to our participants as necessary to manage vomiting due to seasickness. Your signature below acknowledges that you are aware that your patient may be offered these medications at sea and approve of their use as required.*

If your patient should not take any one of these medications due to a medical contraindication, please note that contraindication below:

- ***Meclizine (Bonine) is contraindicated because:*** _____
- ***Ondansetron (Zofran) is contraindicated because:*** _____
- ***Promethazine (Phenergan) is contraindicated because:*** _____

Physician signature: _____

Parent/Guardian signature for student under 18: _____

Examination

In addition to your findings during this physical exam, or knowledge of 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.): _____

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.*

In your medical opinion, is this person a Tuberculosis risk: NO_____ YES_____ (attach documentation if yes)
If you believe a skin test or chest x-ray is warranted, please include results. With your help, we can monitor risk for our entire shipboard community.

Required Immunization:
Tetanus Toxoid series. Date of last vaccination (must be **within 7 years** or booster is required): _____

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."*

I certify that my relationship with the student and his/her family is one of a strictly professional nature.

NAME of Licensed Physician, PA or NP (please print): _____

SIGNATURE of Licensed Physician, PA or NP: _____

Address: _____

Phone #: _____ Email: _____ Date: _____

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

Submission of this form is the first step in SEA's Medical Clearance Process, which is required of all personnel planning to join our ships.