



RLS Dept
 1600 Holloway Ave
 San Francisco, CA 94132-4161

Confidential Medical Record

Part I: General Information

For Participant: Please FILL in EVERY blank, mark N/A if not applicable.

1. Course _____ Start Date ____/____/____
2. Name _____
 Occupation _____ Birth Date _____ Age at Program Start _____
 Height ____ ft. ____ in. Weight ____ lbs. Male ____ Female ____ Social Sec. # _____
 Address _____ City, State, Zip _____
 Home (____) _____ Work (____) _____ Cell (____) _____
 E-mail _____ Fax (____) _____ Other (____) _____
 Do you speak and understand English? Yes No
3. Emergency Contact 1
 Name: _____ E-mail _____ Relationship to you _____
 Address _____ City, State, Zip _____
 Home (____) _____ Work (____) _____ Cell (____) _____
4. Emergency Contact 2
 Name: _____ E-mail _____ Relationship to you _____
 Address _____ City, State, Zip _____
 Home (____) _____ Work (____) _____ Cell (____) _____
5. Your General Physician _____ Phone (____) _____ Fax (____) _____
6. Please Note: Each participant is responsible for any medical expenses and should be covered by his/her own sickness and accident insurance.
 Is applicant covered by any hospitalization/medical care policy? Yes No

Signature Required

I consent that I am voluntarily attending this Tall Ship Education Academy program and I give permission for any emergency anesthesia, operation, hospitalization or other treatment which might become necessary. All information will remain confidential in the hands of the trip leader or the vessel's captain. You should know that over the years, many students with a variety of medical/psychological difficulties have successfully completed programs such as ours, but we must be aware of these conditions. Failure to disclose such information could result in serious harm to you and your fellow participants. If you arrive at the program start with a pre-existing condition or injury which is not indicated on your medical form and you are subsequently forced to leave the program because of that condition, you will be charged an evacuation fee and will not receive a refund of tuition. This document will be destroyed by the trip leader at the conclusion of the program.

Applicant's Signature _____

Date _____

(Confidential Medical Record continued)

Part II: Participant History – Past and Present Medical Problems

To be completed by applicant. Please FILL in EVERY blank! Complete disclosure of all medical and mental health considerations is essential. Additional information and/or a physician’s exam may be required if further assessment is needed.

A. Conditions and Symptoms

Do you have, or have you had, any of the following conditions or symptoms?

High Blood Pressure	Yes No	Active Bedwetting	Yes No	Kidney Problems	Yes No
Heart Disease	ف ف	Headaches	ف ف	Thyroid Problems	ف ف
Heart Murmur	ف ف	Blood disorder/anemia/ sickle cell trait	ف ف	Currently Pregnant	ف ف
Irregular Heartbeat	ف ف	Diabetes	ف ف	Hearing Impairment	ف ف
Family history of heart attack	ف ف	Intestinal Problems	ف ف	Vision Impairment	ف ف
Seizure Disorder	ف ف	Anorexia Nervosa	ف ف	Motion Sickness	ف ف
Seizure within past year	ف ف	Bulimia	ف ف	Sleep Walking	ف ف
Bleeding Disorder	ف ف	Neck Problem	ف ف	Back Problem	ف ف
Asthma	ف ف			Shoulder Problem	ف ف
				PMS or menstrual problems	ف ف
				Other	ف ف

If you have answered “yes” to any of the above items, please explain below. Include the following:

- What specific symptoms are occurring
- How often symptom/condition occurs
- How symptom/condition restricts your activity in any way, including your ability to run, lift and climb
- How long symptom/condition lasts
- How you care for symptom/condition
- Date of last occurrence

Item No.	Detailed Description (include restrictions if any)

B. Allergies

Include medicines, foods, bites and stings.

NONE

Allergy – List Below	Reaction	Medication Required (if any)

(Confidential Medical Record continued)

C. Medications You Are Currently Taking

Include psychotropic and over-the-counter medications

NONE

Medication – List Below	Taken For (Condition/Symptom)	Dosage (Size/Frequency)	Date Started	Current Side Effects (If Any)

NOTE: If you are receiving medication, bring double amounts in separate, non-breakable, waterproof containers along with dosage instructions.

Seasickness is a reality of tall ship programs. Seasickness may make it impossible for you to take a prescription medication daily. If you take a daily medication TSEA may require your physician’s approval. Please call the program coordinator if you have any questions about this.

D. Hospitalizations/Emergencies/Urgent Care

Please list any hospital, emergency department, or urgent care visits within the past two years.

NONE

Date of Visit/Admittance	Reason	Length of Stay

E. Personal History

Are you currently in counseling or treatment with a counselor, psychiatrist, psychologist, or prescribing physician? Yes No

Please check the appropriate responses that indicate the reason(s) for counseling:

- Academic Divorce Maintenance of Medication Other _____
- Career Eating Disorder Substance Abuse
- Depression Family Issues Suicide

F. Life-style

Do you use alcohol? No Yes How much/how often? _____

Do you use tobacco? No Yes How much/how often? _____

Do you use drugs (other than prescription or alcohol) on a regular basis? No Yes

If yes, please describe _____

Do you have a history of, or currently have, a substance abuse or dependency problem? ? No Yes

If yes, please list substance(s) _____ Date(s) last used? _____ / _____ / _____

G. Current Exercise Activity

Activity	Frequency	Approximate Time/Distance	Intensity (check one)
			<input type="checkbox"/> Leisurely <input type="checkbox"/> Moderately <input type="checkbox"/> Intensely
			<input type="checkbox"/> Leisurely <input type="checkbox"/> Moderately <input type="checkbox"/> Intensely
			<input type="checkbox"/> Leisurely <input type="checkbox"/> Moderately <input type="checkbox"/> Intensely

NOTE: You will be expected to engage in moderate physical activity during your Tall Ship Program. You will improve your experience if you start (or continue) a conditioning program in preparation for your course.

Comments (optional) _____

H. Verification of Medical Insurance

Please provide the following information about your medical insurance.

Name of primary person insured _____

Name of Insurance Company _____

Policy Number: _____ Subscriber ID _____

Insurance Company Phone Number _____

ATTACH A PHOTOCOPY OF YOUR INSURANCE CARD OR OTHER VERIFICATION OF COVERAGE TO THIS FORM.

I. Current Conditions

Please describe any current injuries, conditions and/or concerns (that have not been identified above) you have that might limit your full participation in the Week for Women program.

Signature Required

I acknowledge that this medical history is true and complete to the best on my knowledge. The trip leader will review this form and contact you with any concerns she might have. You may be asked to get a physician's approval for your participation.

Applicant's Signature

Date