

SEA Semester Class # _____
Circle one: Atlantic Pacific

For Office Use Only:

Cleared

SEA EDUCATION ASSOCIATION
Confidential
Medical Record and Student Information

Instructions: Student must have a thorough physical exam not more than 3 months prior to arrival at SEA.
Student completes and signs Part I and Part II. Physician completes and signs Part III.

Return COMPLETED form to SEA prior to program:
SEA Student Services, P.O. Box 6, Woods Hole, MA 02543

You must notify SEA of any changes that occur after your exam.

Part I - General Information (Completed by Student)

Name _____ Male _____ Female _____

Home Address _____

Home Phone () _____ Age _____ Date of Birth _____

Family Physician _____ Telephone () _____

Physician's Address _____

Person to be notified in case of illness or injury:

Name _____ Relationship _____

Address _____

Home Phone _____ Business Phone _____

Medical Insurance

You **MUST** be covered by a sickness and accident policy, which is valid in foreign countries. Please complete the information below and sign **confirming this policy will be in effect during your entire program**.

Insurance Company _____ Policy Number _____

Subscriber _____ Relationship to you _____

Signature _____

How would we reach this company if necessary? Phone Number: _____

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:

Part II - Medical History (Completed by Student)

With **sufficient lead-time** (long before arrival at SEA) we can often include students who might otherwise not be able to sail. We are able to make certain accommodations for managing medical conditions aboard ship **only with advance planning.**

To the **Student:** If you have had any of the following conditions or are currently experiencing any of them, please put a check next to the number so that your Physician can give details.

- Problems with vision or hearing (glasses, contacts or hearing aid). Please circle.
- Problems with teeth.
- Dizzy spells, fainting, convulsions, persistent headaches
- Frequent infection of throat, tonsils, sinuses, ears
- Chronic cough, bronchitis, bloody sputum
- Shortness of breath, asthma
- Chest pains upon exertion or deep breathing
- Palpitation of the heart, murmurs, irregular beat, poor circulation
- Jaundice or hepatitis, frequent diarrhea or bloody stools
- Severe menstrual cramps, frequent abdominal cramps
- Kidney stones or infections
- Chronic skin problems (rash, infection)
- Any severe injury to head, chest, or internal organs
- Urinary tract infections, painful or frequent urination, bed wetting
- Illness requiring hospitalization or prolonged incapacitation
- Frequent nausea or vomiting, food intolerances, indigestion/heartburn
- Cramps, heat exhaustion, or other reaction to high temperatures
- Claustrophobia, agoraphobia, acrophobia (strong fear of confined places, open areas, heights)
- Continuing use of alcohol, drugs, or medicines
- Diabetes, thyroid condition, bleeding problems, or epilepsy
- Episodes of depression, anxiety, hysteria or nervousness
- Venereal disease or sexually transmitted disease
- Motion sickness
- Low or high blood pressure
- Hernia
- Hypoglycemia
- Appendicitis
- Eating Disorder
- Dietary Restrictions
- Pregnancy (current)
- Broken bones, dislocations, sprains
- Joint pains, swelling, or stiffness
- Chronic pain in neck, back, or limbs

Have you received (list dates), or are you currently receiving, psychiatric/psychological diagnosis or treatment? If so, please print doctor's name & address and 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. _____

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.)

Date: _____ Printed Name: _____

Student Signature (required): _____

Parent/Guardian must cosign for students who will be less than 18 years of age at time of enrollment.

(Parent/guardian name & signature)

Part III (Completed by the Physician)

Information for the Physician. **Please read carefully.**

SEA Semester programs involve six-week voyages on research vessels and up to 30 days on the ocean at one time 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.

Students 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 student to withdraw from the 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 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)

General Health. 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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Seasickness: SEA ships carry **meclizine** and **promethazine** for treating seasickness. The captain may make these medications available to students with the approval of student's physician AND parent/guardian (if under 18).

Physician: I approve / I do NOT approve (circle one) offering the above medications to this student for treating seasickness. _____
 (physician signature)

Parent/guardian: I approve / I do NOT approve (circle one) offering the above medications to my daughter/son for treating seasickness. _____
 (parent/guardian signature for student under 18)

How long have you known the Student? _____

Do you feel that further diagnostic examination and treatment is indicated? _____

*"I have examined the Student 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 _____