For SEA use only: ❍ Cleared By _____ Date _____

Sea Education Association, Inc.

Confidential Medical Record Form
Shore-based programs

PROGRAM: _____

Instructions: A physical exam should be completed by a medical professional (MD, PA or NP) within one year of beginning the program. You must attach your doctor's standard physical examination record to this form to document your examination. **You MUST notify SEA of ANY changes in medical condition PRIOR to the start of the program.**

PART I - GENERAL INFORMATION (Completed by Parent/Guardian for student)

Full Name _____ ❍ Male ❍ Female

Home Address _____ E-mail Address _____

City _____ Cell Phone ( ) _____

State _____ Zip _____ Date of Birth _____

Country (if not USA) _____

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 Address _____

MEDICAL INSURANCE

We require that you 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 Number _____ Subscriber Phone Number _____

SWIMMING ABILITY

Please let us know if you can remain afloat, unassisted, for 30 minutes: ❍ Yes ❍ No

DIETARY RESTRICTIONS

Have you previously or do you have any dietary allergies, restrictions? Please Explain: _____

_____

Do you follow any of the following diets? ❍ Vegan ❍ Vegetarian ❍ Gluten-free ❍ Lactose-free

PART II - MEDICAL HISTORY (Completed by Parent/Guardian for student)

Please submit **an honest, accurate and complete medical history.** With sufficient lead-time, we are usually able to accommodate most medical conditions in the program. If you have had past or current history with **ANY** of the following, please check the appropriate box, circle and explain below.

Current	Past	
❍	❍	Vision problems, eye disease, surgery, color blindness, glaucoma, glasses or contacts
❍	❍	Dizzy spells, fainting, convulsions, seizures, vertigo
❍	❍	Persistent headaches, migraines
❍	❍	Any severe injury to head, chest, or internal organs
❍	❍	Frequent infection of throat, tonsils, sinuses, or ears
❍	❍	Asthma, shortness of breath, chronic cough, bronchitis, tuberculosis, bloody sputum
❍	❍	Heart condition, irregular heartbeat, heart palpitation, murmurs, pain or angina, heart attack, congestive heart failure, surgery, pacemaker, poor circulation
❍	❍	Low/high blood pressure
❍	❍	Anemia, Hepatitis, Jaundice
❍	❍	Frequent nausea/vomiting, food intolerances/allergies, dietary restrictions, indigestion/heartburn
❍	❍	Gastrointestinal bleeding, Crohn's Disease, Ulcerative colitis, Gallbladder stone or surgery, frequent diarrhea or bloody stools
❍	❍	Eating Disorder
❍	❍	Hypo/hyper glycemia
❍	❍	Severe menstrual cramps, frequent abdominal cramps
❍	❍	Urinary tract infections, painful or frequent urination, bed wetting
❍	❍	Hernia, Appendicitis
❍	❍	Kidney stones or infections, dialysis, transplant

Current	Past	
❍	❍	Diabetes, thyroid condition, bleeding problems, or epilepsy
❍	❍	Venereal disease or sexually transmitted disease
❍	❍	Chronic skin problems (rash, infection)
❍	❍	Hearing Loss, hearing aids
❍	❍	Motion/ sea sickness
❍	❍	Broken bones, dislocations, sprains
❍	❍	Joint pains, swelling, stiffness, or dislocation
❍	❍	Chronic pain in neck, back, or limbs
❍	❍	Back Injury or surgery, ruptured/herniated disc
❍	❍	Nerve pain or damage, sciatica
❍	❍	Illness requiring hospitalization or prolonged incapacitation
❍	❍	Cramps, heat exhaustion, or other reaction to high temperatures
❍	❍	Narcolepsy, sleep apnea, restless leg, sleep walking
❍	❍	Claustrophobia, agoraphobia, acrophobia (strong fear of confined places, open areas, heights)
❍	❍	ADHD or ADD, Learning disability
❍	❍	History of depression, anxiety, hysteria or nervousness, Post-Traumatic Stress Disorder (PTSD)
❍	❍	Continuing use of alcohol, drugs, or medicines
❍	❍	Pregnancy (current)
❍	❍	Problems with teeth.

When was your last dental exam? _____

Did you check any boxes above?

If so, please provide details of the medical condition, both past and present: (Please attached 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. 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:

_____

_____

ALLERGIES

Are you allergic to any of the following:

Medications (penicillin, aspirin, sulfa etc.) _____

Foods (shellfish, nuts etc.) _____

Insect Bites, Other (wool, feathers, detergents) _____

If allergic, what is the reaction?_____

_____

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 a summer camp. In the event I cannot make a decision in an emergency, I hereby authorize the Sea Education Association, Inc. (SEA), its Doctor(s) 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.

_____

Print Student Name Clearly

_____ _____

Signature of Student (required) *Date*

_____

Print Parent/Guardian Name Clearly

_____ _____

Signature of Parent/Guardian (required) *Date (required)*