Sisters Under Sail
Registration & Medical Information Form

TRAINEE INFORMATION

TRAINEE NAME: _____

NICKNAME: _____

DATE OF BIRTH: _dd_/_mm_/_yyyy_ AGE AT TIME OF VOYAGE: _____

IF APPLICABLE, GOING INTO GRADE: _____

CITIZENSHIP: _____ (NON-US RESIDENTS MUST PROVIDE A VALID PASSPORT)

PASSPORT INFORMTION REQUIRED FOR ANY PASSAGE THAT TRAVELS ACROSS THE U.S. AND CANADIAN BORDER:

- Passport issued in what country_____
- Passport number_____
- Place of birth: _____

PRIMARY ADDRESS: _____

CITY _____STATE/PROVINCE _____ZIP_____

PREFERRED EMAIL_____

HOME PHONE_____

TRAINEE'S CELL_____

PARENTS/LEGAL GUARDIANS REQUIRED INFORMATION

MOTHER'S NAME: _____

FATHER'S NAME: _____

MOTHERS'S CELL: _____FATHER'S CELL: _____

IN CASE OF EMERGENCY: _____RELATIONSHIP:_____

HOME PHONE: _____CELL PHONE: _____ WORK: _____

HEALTH AND MEDICAL CARE RELATED INFORMATION

HEALTH INSURANCE CARRIER: _____

NAME OF INSURED: _____

GROUP #: _____

ID#: _____

A FRONT AND BACK COPY OF INSURANCE CARD MUST ACCOMPANY THIS FORM

PHYSICIAN'S NAME: _____ PHONE: _____

PHYSICIAN'S ADDRESS: _____

DATE OF LAST PHYSICAL: _____

DENTIST'S NAME: _____PHONE: _____

DENTIST'S ADDRESS: _____

TRAINEE'S WEIGHT _____ HEIGHT _____

HAS THIS TRAINEE HAD ANY OF THE FOLLOWING?

ASTHMA ___ HEPATITIS ___ MIGRAINE ___ DIABETES ___ EPILEPSY OR SEIZURES ___ DIZZINESS/FAINTING ___

SINUSITIS ___ HEART CONDITION ___ CHICKEN POX ___ MUMPS ___ EARACHES ___ SKIN CONDITION ___

SEVERE STOMACH ACHES ___ SLEEP WALKING ___ MENSTRUAL CRAMPS ___

ARE THERE ANY OTHER HEALTH PROBLEMS THAT WE SHOULD KNOW ABOUT?

_____

_____

_____

_____

_____

IS THIS TRAINEE AFRAID OF HEIGHTS? YES ___ NO ___ NOT SURE ___

CAN THIS TRAINEE SWIM? YES ____ NO ____ COMMENTS _____

DOES THIS TRAINEE HAVE NORMAL HEARING? YES ___ NO ___

IF NO, DOES THE TRAINEE USE A HEARING AID? YES ___ NO ___

DOES THIS TRAINEE HAVE NORMAL VISION WITH OR WITHOUT CORRECTIVE GLASSES OR CONTACT LENSES? YES ___ NO ___

DOES THIS TRAINEE WEAR EYEGLASSES? YES ___ NO ___

DOES THIS TRAINEE WEAR CONTACT LENSES? YES ___ NO ___

IS THIS TRAINEE FULLY IMMUNIZED? YES ___ NO ___

DATE OF LAST TETANUS: _____

DOES THIS TRAINEE HAVE ANY ALLERGIES? PLEASE LIST ANY KNOWN ALLERGIES AND IDENTIFY ANY HISTORY OF SERIOUS ALLERGIC REACTIONS:

_____

_____

_____

_____

DOES THIS TRAINEE HAVE ANY SPECIAL DIETARY NEEDS?

_____

DOES THIS TRAINEE REQUIRE ANY REGULAR MEDICATION OR MEDICAL TREATMENT?

_____

_____

_____

_____

NOTE: ALL MEDICATION, PRESCRIPTION AND NON-PRESCRIPTION, ARE GIVEN TO THE SHIP'S MEDICAL OFFICER FOR SAFEKEEPING. **WRITTEN INSTRUCTIONS MUST ACCOMPANY SUCH MEDICATIONS SO THAT THEY MAY BE GIVEN TO THE TRAINEE/INTERN AS REQUIRED.**

OTHER NOTES

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Sail training courses are physically demanding. Our ship operates in all weather, 24 hours a day. TRAINEES live in close quarters and are encouraged to participate in all ship routines and program activities (swimming, keeping watch, going aloft, performing emergency drills, maintenance work, etc.) It is essential for the safety of the TRAINEES and the total ship's company that TRAINEES be medically and psychologically fit.

Our ship is supplied with first aid equipment and our officers are certified to deliver emergency first aid. We also have satellite telephones and cellular phones aboard which allow us to communicate with medical personnel, if required. Nevertheless, **it is important to recognize that our ship is sometimes many hours away from acute care medical services**. If a TRAINEE has a pre-existing condition (diabetes, asthma, seizure disorder, etc.) which may require emergency care during a course, please consult your physician and disclose the condition (see below) before signing this release.

It is the policy of Sisters Under Sail to control the use of all medications (prescription and/or non-prescription) while your child is aboard ship. Therefore, all medications are to be placed in a labelled Ziploc baggie with instructions from you, her legal guardian. We do dispense seasickness medication as needed.

I have read the information above and completed the medical information form. To the best of my knowledge, myself or daughter/ward is in good health and able to participate fully in Sisters Under Sail's sail training program. I give my permission for Sisters Under Sail to contact the physicians named above if more medical information is required. In case of a medical emergency, I give my permission for the employees and agents of Sisters Under Sail to administer first aid, and if I am not available for consultation, to select a physician who will secure proper medical treatment (including examination, medication, treatment, anaesthesia or surgery) for myself or my above named daughter/ward.

By signing this document I, _____(TRAINEE or parent/legal guardian of TRAINEE under the age of 18), acknowledge that I have read and have provided accurate information regarding the TRAINEE/INTERN. I also acknowledge that I have read and understand the Sisters Under Sail Handbook.

SIGNATURE: _____

DATE: _____

I, _____(TRAINEE), acknowledge that I have read and understand the Sisters Under Sail Handbook.

TRAINEE SIGNATURE: _____

DATE: _____

PAYMENT INFORMATION

PLEASE MAKE CHECKS PAYABLE TO SISTERS UNDER SAIL.

Send payment and other documentation to:

Sisters Under Sail
2 Gravel Hill Road
Asbury, NJ 08802

TO PAY BY CREDIT CARD, PLEASE VISIT OUR PAYPAL LINK AT SISTERSUNDERSAIL.ORG