

Health & Medical Record of Participant

All applicants must consult their family physician if there is any doubt as to their suitability to take part in this sailing adventure. Please complete this form in its entirety.

Crew/Troop/Group Name _____

Name of Participant _____ Date of Birth _____ Age _____

Home Address _____

City _____ State _____ Zip Code _____ Home Phone # _____

Attach a Photocopy of insurance card. If family has no medical insurance, state "None"

Family Medical Insurance Company _____ Policy # _____ Phone # _____

Address of Insurance Company _____ City _____ State _____

In Case of Emergency Notify: Name _____ Relationship _____

Address _____ City _____ State _____ Zip Code _____

Contact Phone # _____ Second Contact Phone # _____

Alternate Contact Person _____ Phone # _____

Participant Health History

Are you now, or have you ever been treated for any of the following: Answer "Yes" or "No"

Sinus trouble _____ Kidney Disease _____ Earaches/infections _____ Abdominal problems _____ Epilepsy _____

Hay fever _____ Tuberculosis _____ Fainting spells _____ Rheumatic fever _____ Asthma _____

Ear problems _____ Pneumothorax _____ Seizures _____ High blood pressure _____ Hypertension _____

Heart trouble _____ Diabetes _____ Frequent diarrhea _____

Any mental illness _____ Explain _____

Allergies or reactions to medication _____ What medications _____

Allergy to insects or jellyfish stings _____

Have you had more than a brief illness, injury, or emotional difficulty during the past year? If so, what _____

Have you had any operations, serious injury or hospitalization within the last year? If so, what _____

Any restriction of activity for medical reasons? _____ Explain _____

Have you taken any medication for more than 2 weeks in the past year? _____ What _____ Why _____

Are you now taking any medication or treatment? _____ Why _____

If you have any special food requirements, please bring food to supplement your particular needs.

Current Medication

Be sure to bring needed medication while on Ciganka

Medication	Dosage
_____	_____
_____	_____
_____	_____
_____	_____

Parent's/Guardian's authorization is required for those under 18 yrs.

I, the undersigned, have read and understand the entire form. This health history of the applicant is accurate and complete, and the person herein described has permission to engage in all High Adventure Sailing activities on "Ciganka", except as specifically noted on this form. If I cannot be reached in an emergency, I hereby give permission for health advisor, or the adult advisor in charge, to treat, hospitalize, secure anesthesia or to order injection, surgery, or other treatment needed for the person described therein. While on this trip, the health advisor or adult leader has permission to obtain all information connected with treatment by physician, hospital, or other treatment facility.

Information above is accurate and complete

Applicant's signature (required) Date

Parent/Guardian signature Date
(required if applicant is under 18 years of age)