Schooner Ernestina
Participant Medical Information

Please Print Clearly

Participant Name: _____ Sex: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Work/Cell Phone: _____

If participant is under 18, Parent's Names: _____

Address: _____

Home Number: _____ Work/Cell Number: _____

Emergency Contact Information:

Name_____ **Relationship**: _____

Home phone: _____ Work phone: _____

Medical Insurance? Yes No Company or provider: _____

Provider Phone: _____ Policy #: _____

Physician's Name: _____ Physician's Phone: _____

Medical Information

Do you wear contacts? _____ Do you have a chronic illness'? _____
Do you have asthma? _____ Heart disease? _____
Do you have diabetes? _____ Have you had your appendix removed? _____

If "yes" to any of the above, please explain: _____
_____

Please indicate any **other medical situations** you have or have had, including serious accidents or surgeries and their dates _____
_____

Do you have any **allergies**? Yes No
If yes, please list all, including medical, environmental, and food. Please indicate if any are life threatening. _____
_____

Do you have any **disabilities**? Yes No
If yes, please list, and explain any special accommodations that might be necessary for participation. _____
_____
_____

Participant Medical Information
Continued

Participant Name_____

Do you take any **medications**? Yes No
If yes, please list

Name	**Amount**	**For what is it prescribed?**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is it safe for you to take **seasickness medication**? Yes No
If not, explain: _____
_____
_____

Do you have any **dietary restrictions**? Yes No
If yes, explain: _____
_____
_____

What is your **swimming ability**? Cannot swim _____
Cannot swim over 50 yards_____
Can swim over 50 yards_____
WSI _____

This Section must be completed by Participant (If under 18, must be signed by parent or guardian.)

The information and health history stated above is correct to the best of my knowledge. I hereby give permission to the medical personnel selected by the Ernestina Staff to order tests and treatment for my minor child or myself and in the event the person to be notified in case of emergency cannot be reached. I hereby give my permission to the physician selected by the Ernestina staff to hospitalize and secure proper treatment for minor child or myself.

Signature_____Date_____
Witness_____Date_____

Schooner Ernestina Commission
89 North Water Street
New Bedford, MA 02740
(508) 992-4900
Programs@Ernestina.Org