SCHOONER MARTHA FOUNDATION

(347) 746-8851
PO Box 1811 Port Townsend, WA 98368

MEDICAL HEALTH & PERSONAL HISTORY

NAME:_____ DATE OF BIRTH: _____ AGE: ___ GENDER: _____
PHYSICIAN:_____ PHONE:_____
INSURANCE:_____ POLICY #: _____

PLEASE INDICATE CURRENT CONDITIONS:

Ear infection, bleeding/clotting disorders, hypertension, asthma, heart disease, muscular/skeletal disorders, seizures, diabetes, and other conditions. Please Explain:

_____
_____
_____
_____
_____
_____

PLEASE INDICATE ALL CONDITIONS SINCE LAST HEALTH EXAM: Injury, medication, hospital treatment, contagious diseases, physical activity restrictions. Please Explain:

_____
_____
_____

PLEASE LIST ANY FOOD ALLERGIES AND DIETARY NEEDS:

_____
_____
_____

OTHER HEALTH CONDITIONS AND PERSONAL HISTORY:

Hearing impairment, vision correction, emotional disturbances, fainting, aquaphobia, acrophobia, motion sickness, claustrophobia. Please Explain: _____

_____
_____

On a scale of 1-10, what is participants swimming ability:

DRUGS/PRESCRIPTIONS: Medication must be in original labeled container for participants; minors cannot carry medication; the Captain must be informed of all medicines upon boarding.

Current Medications:_____ Amount/frequency to be administered:_____ Purpose:____

Signature of participant:_____ Date:_____

Signature of parent / guardian _____ Date:_____