Clearwater™

724 Wolcott Avenue
Beacon, NY 12508
Phone:845 265 8080
Fax: 845 831 2921

Office Notes:

Approved By _____Date ____/____/_____

Confidential Medical Record

Program Dates: ____/____/_____ to ____/____/_____

Instructions: all questions on this form are important. The answers are needed in order to assess your level of participation in the program. Please answer every question to every section and return the form as soon as possible, in order to allow time for any follow-up. This is a general health form used for onboard volunteers and participants in our education programs.

Part 1 General Information

PROGRAM_____

APPLICANT

Last_____ First _____
Gender □ Female □ Male
Age _____ DOB ____/____/_____
Address:_____ Apt._____
City _____ State_____ Zip_____

Home #( ) _____ _____
Cell # ( ) _____ _____
Other # ( ) _____ _____
Email: _____@_____
Language spoken at home?_____

PARENT / GUARDIAN (If under 18)

Last _____ First _____
Home # ( ) _____ _____
Cell # ( ) _____ _____
Other # ( ) _____ _____
Email: _____@_____

PARENT / GUARDIAN (If under 18)

Last _____ First _____
Home # ( ) _____ _____
Cell # ( ) _____ _____
Other # ( ) _____ _____
Email: _____@_____

EMERGENCY CONTACT (other than parent / guardian)

Last _____ First _____
Cell # ( ) _____ _____
Relationship _____
Home # ( ) _____ _____
Other # ( ) _____ _____

Ethnic Background (Optional)

□ Asian Caucasian □ (Non-Hispanic) □ American Indian / Alaskan Native
□ Multi-Ethnic □ Native Hawaiian or Pacific Island □ Choose Not to Answer
□ Hispanic/Latino □ African American □ Do Not Know Ethnicity
□ Other_____

Insurance Information: Each participant is responsible for any medical expenses and should be covered by his/her own illness and accident insurance. (Please answer the following questions for our insurance records (please attach a photo copy of both the front and back of your insurance card)

Do you have insurance? □ No □ Yes
Insurance Company _____
Prescription Plan # _____
Policy/Certificate # _____
Telephone # ( ) _____ _____

FAMILY PHYSICIAN

Name _____ Telephone #_____ FAX#_____

Part 2 Medical Information

Allergies (including allergies to medicines, foods, insects bits/stings) □ **NONE** or……..

Allergy	Reaction	Medications Required (if any)

Current Medications (including psychiatric, over the counter, inhalers, herbal supplements) □ **NONE** or……..

Medications	Taken for: (Symptom/condition)	Dosage	Date Started	Current Side Effects

* If participant is under 18, all medications will be collected and administered by our medical officer *

PARTICIPANT: Last_____ First _____ **Program Dates:** ____/____/_____ to

Part 3 Health Profile

#	Please √ one – if yes, Describe below	Y	N	#	Please √ one – if yes, Describe below	Y	N
1	Seizure with in the last year			6	Use of tobacco/smoker		
2	Hospitalization/Emergency room/ urgent care within the last year			7	Current neck/ back/shoulder/knee/ankle other joint problem		
3	Asthma (if yes bring inhaler)			8	Currently pregnant		
4	Unexplained chest pain/pressure, shortness of breath, rapid heartbeat, sweats, or exertional dizziness and or faint spells			9	Bed wetting		
				10	Diagnosed Learning disability and or ADD/ ADHD		
5	Other cardiac conditions, e.g., heart murmur or other rhythm abnormality			11	Other medical issues/illness/symptoms/ requirements/prosthetic device(s)		
#	Describe:						
#	Describe:						
#	Describe:						

B. Personal History

1 Have you ever been diagnosed or treated for any of the following within the past two years?

____Attention deficit Disorder (ADD)
____Adjustment Disorder
____Anxiety Disorder
____Disruptive Behavior Disorder
____Eating Disorder
____Impulse Control Disorder
____Learning Disorder
____Mental Disability
____Mood Disorder
____Personality Disorder
____Pervasive Development Disorder
____Schizophrenia
____Substance Related Disorder

2 Have you received treatment or therapy for any of the above conditions?

____Medications
Out Patient Counseling
____Day Treatment
Residential Treatment
____Hospitalization

3 Are you currently (or within the past 1 year) taking medication(s) to treat any mental health issue **____YES ____ NO**

4 Have you experienced any of the following significant events within the last year?

____Serious Illness ____Self Harm ____Incarceration ____Serious Injury _____Hospitalization ____Death

5 When was your last tetanus shot? _____(date)
It is required that all participants have a current tetanus Immunization (within 10 years).

6 Do you have any dietary restrictions? _____ Vegetarian _____ Vegan _____Allergies _____None

Signature Required Consent is hereby given for the applicant to attend a Clearwater program and permission is given for any emergency anesthesia, operation, hospitalization or other treatment that may become necessary. All information will remain confidential. Students with of variety of mental/psychological difficulties qualify for our programs, but we must be made aware of these conditions. Failure to disclose such information could result in serious harm to you and your fellow participants

Parent/Guardian Signature _____ Print _____ Date _____/_____/_____
(If applicant is under the legal age)

Applicant Signature _____ Print _____ Date _____/_____/_____

Please Return This Form to the Office

Clearwater™

Hudson River Sloop Clearwater
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Fax: 845 831 2921

educator@clearwater.org