



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 or POSITION: _____

APPLICANT	
Last _____ First _____	Home # () _____
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> _____	Cell # () _____
Age _____ DOB ____/____/____	Other # () _____
Address: _____ Apt. _____	Email: _____@_____
City _____ State _____ Zip _____	Language spoken at home? _____
PARENT / GUARDIAN (If under 18)	PARENT / GUARDIAN (If under 18)
Last _____ First _____	Last _____ First _____
Home # () _____	Home # () _____
Cell # () _____	Cell # () _____
Other # () _____	Other # () _____
Email: _____@_____	Email: _____@_____
EMERGENCY CONTACT (other than parent / guardian)	
Last _____ First _____	Relationship _____
Cell # () _____	Home # () _____
	Other # () _____
Ethnic Background (Optional)	
<input type="checkbox"/> Multi-Ethnic	<input type="checkbox"/> (Non-Hispanic)
<input type="checkbox"/> Caucasian	<input type="checkbox"/> Native Hawaiian or Pacific Island
<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> African American
<input type="checkbox"/> Asian	<input type="checkbox"/> Other _____
<input type="checkbox"/> American Indian / Alaskan Native	<input type="checkbox"/> Choose Not to Answer
<input type="checkbox"/> Do Not Know Ethnicity	
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? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Insurance Company _____	Policy/Certificate # _____
Prescription Plan # _____	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) Impulse Control Disorder Personality Disorder
 Adjustment Disorder Learning Disorder Pervasive Development Disorder
 Anxiety Disorder Mental Disability Schizophrenia
 Disruptive Behavior Disorder Mood Disorder Substance Related Disorder
 Eating Disorder

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

Medications Day Treatment Hospitalization
 Out Patient Counseling Residential Treatment

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 of a loved one

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



Hudson River Sloop Clearwater
Attn: Educator
724 Wolcott Avenue **Phone: 845 265 8080**
Beacon, NY 12508 **Fax: 845 831 2921**

educator@clearwater.org