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 _____
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)

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

COVID-19 Liability Release Waiver

****Signature Required****

Due to the ongoing Coronavirus (COVID-19) pandemic, Clearwater is doing everything we can to protect our crew, our volunteers, and our community. We ask that you complete and return this form before your time onboard to ensure a safe, meaningful experience for everyone.

I agree to the following:

- ☐ I am fully vaccinated (to be fully vaccinated includes the booster shot). I will not be permitted to board the vessel without showing proof of vaccination.
- ☐ I will produce a negative COVID-19 test from within 24 hours of their arrival to the vessel.
- ☐ If I feel sick on the day that I am scheduled to arrive, I will reschedule my time onboard.
- ☐ If I feel sick during my time onboard, I will tell the captain immediately, wear a mask, and test for COVID-19.
- ☐ If I test positive for COVID-19 while I am onboard, I will tell the captain immediately, wear a mask, and will make plans to leave the vessel as soon as possible.
- ☐ If I test positive for COVID-19 in the 5 days after my time onboard, I will notify the Onboard Educators immediately.
- ☐ Clearwater cannot be held liable for any exposure to the Coronavirus (COVID-19) during time onboard.
- ☐ As an onboard volunteer, I acknowledge that I will be a part of the sloop's crew for the duration of my stay onboard and will adhere to the rules that apply to the crew.
- ☐ I understand that Clearwater's COVID-19 rules and protocols may change in accordance with evolving state and federal guidance. I agree to abide by all Clearwater COVID-19 rules and protocols if such changes occur.

By signing below, I acknowledge that I have read, understood, and agree to abide by all of Clearwater's COVID-19 protocols for onboard volunteers. I understand that these protocols may change and that if at any time, I do not think I can adhere to all protocols, I will not come onboard the vessel or will reschedule my time onboard to when I can adhere to all protocols. I agree to release Clearwater from any and all liability for the unintentional exposure to or harm caused by the Coronavirus (COVID-19).

Name (Print): _____

Name (Signature): _____

Date: _____/_____/_____

Name of Legal Guardian if not 18 or older (Print):

_____

Name of Legal Guardian if not 18 or older (Signature):

_____

Date: _____/_____/_____