



724 Wolcott Avenue
Beacon, NY 12508

Phone: 845 265 8080
Fax: 845 831 2921

Office Notes:

Approved By _____ Date ____ / ____ / ____

Confidential Medical Record

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)
 Caucasian Native Hawaiian or Pacific Island
 Hispanic/Latino African American
 Asian Other

American Indian / Alaskan Native
 Choose Not to Answer
 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? 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			#	Please √ one – if yes, Describe below		
	Y	N			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		
5	Other cardiac conditions, e.g., heart murmur or other rhythm abnormality			10	Diagnosed Learning disability and or ADD/ ADHD		
#	Describe:						
#	Describe:						
#	Describe:						

B. Personal History

1	Have you ever been diagnosed or treated for any of the following within the past two years?							
<input type="checkbox"/> Attention deficit Disorder (ADD)		<input type="checkbox"/> Impulse Control Disorder		<input type="checkbox"/> Personality Disorder		<input type="checkbox"/> Pervasive Development Disorder		
<input type="checkbox"/> Adjustment Disorder		<input type="checkbox"/> Learning Disorder		<input type="checkbox"/> Mental Disability		<input type="checkbox"/> Schizophrenia		
<input type="checkbox"/> Anxiety Disorder		<input type="checkbox"/> Mental Disability		<input type="checkbox"/> Mood Disorder		<input type="checkbox"/> Substance Related Disorder		
<input type="checkbox"/> Disruptive Behavior Disorder		<input type="checkbox"/> Mood Disorder						
<input type="checkbox"/> Eating Disorder								
2	Have you received treatment or therapy for any of the above conditions?							
<input type="checkbox"/> Medications		<input type="checkbox"/> Day Treatment		<input type="checkbox"/> Hospitalization		<input type="checkbox"/> Residential Treatment		
<input type="checkbox"/> Out Patient Counseling								
3	Are you currently (or within the past 1 year) taking medication(s) to treat any mental health issue <input type="checkbox"/> YES <input type="checkbox"/> NO							
4	Have you experienced any of the following significant events within the last year?							
<input type="checkbox"/> Serious Illness		<input type="checkbox"/> Self Harm		<input type="checkbox"/> Incarceration		<input type="checkbox"/> Serious Injury		
						<input type="checkbox"/> Hospitalization		
						<input type="checkbox"/> 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? <input type="checkbox"/> Vegetarian <input type="checkbox"/> Vegan <input type="checkbox"/> Allergies <input type="checkbox"/> 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 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
Beacon, NY 12508**

**Phone: 845 265 8080
Fax: 845 831 2921**

educator@clearwater.org