



KALMAR NYCKEL

The Tall Ship of
DELAWARE

Medical Form - CONFIDENTIAL

Date: ____/____/____

D.O.B. ____/____/____

Full legal Name (required for port security)

Last: _____ First: _____ MI: _____ Preferred Name: _____

Sex _____ Glasses Y N Near-sighted Y N Far-sighted Y N
Height _____ Contacts Y N Pace-Maker Y N Hearing Aid Y N
Weight _____

Are you currently under the regular care of a physician? Y N

Are you currently under the regular care of a psychiatrist? Y N

If yes to either question, please describe condition and treatment. _____

Do you have any of the following chronic conditions?

High Blood Pressure? _____
Epilepsy? _____
Heart Disease? _____
Diabetes? _____ If yes, do you take insulin? _____
Breathing Problems? _____, If yes, do you use an inhaler? _____.

Do you have any Allergies? If yes, please list allergies.

Drug Allergies? _____ Food Allergies? _____ Environmental (bees, etc.)? _____

If yes, do you carry an Epinephrine auto-injector ? Y N

Are you currently taking any prescription or regular Over-The-Counter (OTC) medications? Y N

If Yes, Please list all prescription or regular OTC medications you are currently taking: (USE BACK IF NEEDED)

Name of medication	Condition medication treats	Symptoms we'll notice if med. is skipped, or if a medical problem arises related to this condition	Will you bring this medication if on the ship for a day?/week?

To the best of my knowledge, all of the above information is correct. I further understand that any misrepresentation or falsifying of the above information is grounds for immediate dismissal from the ship and Foundation programs. I feel that I am physically and mentally able to participate in the activities onboard and I agree to inform the Master of the *Kalmar Nyckel* if and when any information given on this form changes.

Signature X _____ Staff Witness: X _____

Emergency Contact Name: _____ Relationship: _____
(someone not on ship with you)

Work Phone: (____) _____ - _____ Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

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