



US Brig NIAGARA Sailing Program

Flagship Niagara League, Inc. ♦ 150 East Front Street, Suite 100, Erie, PA 16507 ♦ 814.452.2744 ♦ www.flagshipniagara.org

CONFIDENTIAL

FNL TRAINEE MEDICAL RECORD

Instructions: Applicants must have a thorough history and physical exam not more than 3 months prior to shipboard participation. Applicant completes and signs Section 1 and 2. Examining physician completes and signs Section 3. Final determination for medical clearance will be by the Flagship Niagara League's Doctor.

SECTION 1: General Information (Completed by Applicant)

Name: _____ **Male:** _____ **Female:** _____

Home Address: _____

Home Phone: () _____ **Age:** _____ **Date of Birth:** _____

Family Physician: _____ **Telephone:** () _____

Physician's Address: _____

Person to be notified in case of illness or injury:

Name: _____ **Relationship:** _____

Address: _____

Home Phone: _____ **Business Phone:** _____

Medical Insurance

You **MUST** be covered by a sickness and accident policy. Please complete the information below and sign **confirming this policy will be in effect during your entire program.**

Insurance Company: _____ **Policy Number:** _____

Subscriber: _____ **Relationship to you:** _____

Signature: _____

How would we reach this company if necessary?

Phone Number: () _____

SECTION 1: Release

I hereby authorize the medical practitioner who has signed the physical certification to release to or discuss with *Niagara's* Doctor any pertinent information in his/her possession regarding any medical condition that may require review by *Niagara's* Doctor.

Applicant Name (Print): _____

Applicant Signature: _____ **Date:** _____

*** Parent/Guardian must cosign for applicants who will be less than 18 years of age at time of enrollment.**

Name: _____ **Signature:** _____ **Date:** _____

Authorization

I certify that this medical history, and all information on it, is **complete and accurate**, and that I am physically and emotionally fit to participate in an extended offshore voyage. In the event I cannot make a decision in an emergency, I hereby authorize The Flagship Niagara League, its Doctor(s), ship's Captain or Medical Officer to administer emergency medical treatment and to hospitalize, secure proper treatment for, and to order injections, anesthesia or surgery for me. I give permission for staff to share information from this form if needed for medical purposes. I understand that I am responsible for notifying immediately of any injury, illness, or other medical condition or **change** to the medical information here provided. I certify that I am at least 18 years of age. (If not, parent/guardian must also sign.)

Date: _____ **Printed Name:** _____

Applicant Signature (required): _____

***Parent/Guardian must cosign for applicant who will be less than 18 years of age at time of enrollment.**

(Parent/Guardian name and signature)

SECTION 2: Medical History (Completed by Applicant)

- | | YES | NO | |
|-----|--------------------------|--------------------------|-------------------------------------|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Hearing aid |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Impaired speech or stuttering |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Poor vision |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | History of eye disease or injury |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema or COPD |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | Collapsed lung/pneumothorax |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | Irregular heartbeat |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur or valve replacement |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain or angina |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> | Heart attack/myocardial infarction |
| 13. | <input type="checkbox"/> | <input type="checkbox"/> | Heart surgery/stent/angioplasty |
| 14. | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker or defibrillator |
| 15. | <input type="checkbox"/> | <input type="checkbox"/> | Any other heart condition |
| 16. | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure/hypertension |
| 17. | <input type="checkbox"/> | <input type="checkbox"/> | Aneurysm or blockages |
| 18. | <input type="checkbox"/> | <input type="checkbox"/> | Pulmonary embolus or blood clots |
| 19. | <input type="checkbox"/> | <input type="checkbox"/> | Gastrointestinal bleeding or ulcers |
| 20. | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis or jaundice |
| 21. | <input type="checkbox"/> | <input type="checkbox"/> | Dietary restrictions |
| 22. | <input type="checkbox"/> | <input type="checkbox"/> | Intestinal surgery |
| 23. | <input type="checkbox"/> | <input type="checkbox"/> | Any form of cancer |
| 24. | <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| 25. | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia or polycythemia |
| 26. | <input type="checkbox"/> | <input type="checkbox"/> | Any other blood disorders |
| 27. | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease |
| 28. | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes - Last Hgb/A1C _____ |
| 29. | <input type="checkbox"/> | <input type="checkbox"/> | HIV or AIDS |
| 30. | <input type="checkbox"/> | <input type="checkbox"/> | Lymphoma or leukemia |
| 31. | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| 32. | <input type="checkbox"/> | <input type="checkbox"/> | Kidney transplant or dialysis |
| 33. | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease or cancer |
| 34. | <input type="checkbox"/> | <input type="checkbox"/> | Back surgery or injury |
| 35. | <input type="checkbox"/> | <input type="checkbox"/> | Ruptured/herniated disc |
| 36. | <input type="checkbox"/> | <input type="checkbox"/> | Limitation of any major joint |
| 37. | <input type="checkbox"/> | <input type="checkbox"/> | Bone or joint surgery |

- | | YES | NO | |
|-----|--------------------------|--------------------------|---|
| 38. | <input type="checkbox"/> | <input type="checkbox"/> | Recurrent neck or back pain |
| 39. | <input type="checkbox"/> | <input type="checkbox"/> | Swollen/painful joint or dislocation |
| 40. | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis or bursitis |
| 41. | <input type="checkbox"/> | <input type="checkbox"/> | Amputation or prosthesis |
| 42. | <input type="checkbox"/> | <input type="checkbox"/> | Carpal tunnel |
| 43. | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty walking or climbing |
| 44. | <input type="checkbox"/> | <input type="checkbox"/> | Sciatica or nerve pain |
| 45. | <input type="checkbox"/> | <input type="checkbox"/> | Other bone/joint disorder |
| 46. | <input type="checkbox"/> | <input type="checkbox"/> | Motion/sea sickness |
| 47. | <input type="checkbox"/> | <input type="checkbox"/> | Impaired balance or balance disorder or difficulty |
| 48. | <input type="checkbox"/> | <input type="checkbox"/> | Vertigo or dizziness |
| 49. | <input type="checkbox"/> | <input type="checkbox"/> | Numbness or paralysis |
| 50. | <input type="checkbox"/> | <input type="checkbox"/> | Head injury or skull fracture |
| 51. | <input type="checkbox"/> | <input type="checkbox"/> | Seizures or epilepsy |
| 52. | <input type="checkbox"/> | <input type="checkbox"/> | Recurrent headaches |
| 53. | <input type="checkbox"/> | <input type="checkbox"/> | Narcolepsy |
| 54. | <input type="checkbox"/> | <input type="checkbox"/> | Sleep apnea Use CPAP? Y ¹ N ¹ |
| 55. | <input type="checkbox"/> | <input type="checkbox"/> | Current pregnancy |
| 56. | <input type="checkbox"/> | <input type="checkbox"/> | Fainting spells/loss of consciousness |
| 57. | <input type="checkbox"/> | <input type="checkbox"/> | Stroke or TIA |
| 58. | <input type="checkbox"/> | <input type="checkbox"/> | Brain tumor |
| 59. | <input type="checkbox"/> | <input type="checkbox"/> | Other brain or nerve disease |
| 60. | <input type="checkbox"/> | <input type="checkbox"/> | ADD, ADHD, or bipolar |
| 61. | <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| 62. | <input type="checkbox"/> | <input type="checkbox"/> | History of suicide attempt |
| 63. | <input type="checkbox"/> | <input type="checkbox"/> | Schizophrenia |
| 64. | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety |
| 65. | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol or substance abuse |
| 66. | <input type="checkbox"/> | <input type="checkbox"/> | Loss of memory or amnesia |
| 67. | <input type="checkbox"/> | <input type="checkbox"/> | Other psychiatric disease/counseling |
| 68. | <input type="checkbox"/> | <input type="checkbox"/> | Sleepwalking |
| 69. | <input type="checkbox"/> | <input type="checkbox"/> | Claustrophobia |
| 70. | <input type="checkbox"/> | <input type="checkbox"/> | Fear of heights |
| 71. | <input type="checkbox"/> | <input type="checkbox"/> | Allergic reactions |
| 72. | <input type="checkbox"/> | <input type="checkbox"/> | Any other disease, surgery or hospitalization |

Condition #	Comment (Explain all YES responses. Use reverse side if more space is necessary)

Medications: List All Medications (and dosages/frequency) currently taking

Medication	Dosage/Frequency

ALLERGIES:

Medications: _____

Foods: _____

Insect bites/other: _____

If any allergies are documented, describe the reaction: _____

Swimming Ability:

How would you rate your swimming ability:

Poor Fair Good Excellent

Information for the Physician: (Please read carefully)

The US Brig *Niagara* is a 198ft. long, wooden-hulled authentic replica of an 1813-era US Navy warship. While sailing upon the expansive Great Lakes, participants aboard the vessel may be away from harbors offering medical services for extended periods and will have access to fundamental medical care only. Medical evacuation may not be possible. Participants will be in an environment which is physically and emotionally demanding.

In light of these circumstances, a full disclosure of medical conditions is required. A listing of required physical abilities is attached.

SECTION 3: Physical Examination (Completed by Physician)

Height (inches only):	Weight (lbs):	Body Mass Index (BMI):	Gender:
Pulse Resting:	Initial Blood Pressure:	Repeat Blood Pressure (if needed):	
Vision (with/without correction) Right: Left:		Hearing: Capable of hearing whisper at 5 ft. Right: Y N Left: Y N	

#	Normal	Abnormal	System/Organ	#	Normal	Abnormal	System/Organ
1.			Head, Face, Neck, Scalp	10.			Skin
2.			Eyes/Pupils/EOM	11.			Lymphatic
3.			Mouth and Throat	12.			Neurologic
4.			Ears/Drums	13.			Vascular System
5.			Lungs and Chest	14.			Genitourinary System
6.			Heart	15.			Hernia
7.			Abdomen	16.			Missing Extremities/Digits
8.			Upper/Lower Extremities	17.			General/Systemic
9.			Spine/Musculoskeletal				

Explanation of abnormalities above: _____

Required Immunization:

Tetanus Booster (must be within last 7 years): **Yes:** **No:**

List of tasks considered necessary for performing ordinary and emergency response shipboard functions:		
<i>Shipboard Tasks, function, event or condition:</i>	<i>Related Physical Ability:</i>	<i>The examiner should be satisfied that the applicant:</i>
Routine movement on slippery, uneven, and unstable surfaces.	Maintain balance (equilibrium).	Has no disturbance in sense of balance.
Routine access between levels.	Climb up and down vertical ladders and stairways.	Is able, without assistance, to climb up and down vertical ladders and stairways.
Routine movement between spaces and compartments.	Step over high door sills and coamings, and move through restricted accesses.	Is able, without assistance, to step over a door sill or coaming of 24 in. (61 cm) in height. Able to move through a restricted opening of 36 in.
Open and close watertight doors, hand cranking systems, open/close valve.	Manipulate mechanical devices using manual and digital dexterity and strength.	Is able, without assistance, to open and close watertight doors on vertical hinges that may weight up to 55 pounds (25 kilograms). Should be able to move hands/arms to open and close valve wheels in vertical and horizontal directions; rotate wrists to turn handles. Reach above shoulder height.
Handle ship's stores.	Lift, pull, push, and carry a load.	Is able, without assistance, to lift at least a 20 pound (18.1 kilogram) load off the ground, and to carry, push or pull the same load.
General vessel maintenance.	Crouch (lowering height by bending knees); feel (the ability to handle or touch to examine or determine differences in texture and temperature).	Is able, without assistance, to grasp, lift and manipulate various common shipboard tools.
Emergency response procedures, including escape from smoke-filled spaces.	Crawl (the ability to move the body with hands and knees; feel (the ability to handle or touch to examine or determine differences in texture and temperature).	Is able, without assistance, to crouch, kneel and crawl, and to distinguish differences in texture and temperature by feel.
Stand a routine watch.	Stand a routine watch.	Is able, without assistance, to intermittently stand on feet for up to six hours with minimal rest periods.
React to visual alarms and instructions, emergency response procedures.	Distinguish an object or shape at a certain distance.	Visual acuity of at least 20/40 with or without correction.
React to audible arms and instructions, emergency response procedures.	Adequate hearing.	Hears adequately.
Make verbal reports or call attention to suspicious or emergency conditions.	Describe immediate surroundings and activities, and pronounce words clearly.	Is capable of normal conversation.
Participate in firefighting activities.	Use firefighting equipment.	Be able to carry and handle fire hoses and fire extinguishers.
Abandon ship.	Use survival equipment.	Has the agility, strength and range of motion to put on a personal flotation device and exposure suit without assistance from another individual.

Examining Physician Certification

I have reviewed the applicant's medical history, performed a physical examination, and with knowledge of the physical abilities required for participation on the Sailing School Vessel *Niagara*, I make the following determination:

- Recommend participation
- Do not recommend participation
- Recommend participation with the following restrictions:

Physician Name

Physician Signature

Date

(For Flagship Niagara League Doctor Use Only)

Flagship Niagara League's Doctor Certification

I have reviewed the applicant's medical history and physical examination forms, and with knowledge of the physical abilities required for participation on the Sailing School Vessel *Niagara*, I make the following determination:

- Recommend participation
- Do not recommend participation
- Recommend participation with the following restrictions:

FNL Doctor's Name

FNL Doctor's Signature

Date