

CREW MEDICAL PROFILE

VESSEL: _____

NAME _____ (AGE) _____ PHONE # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HEIGHT _____ WEIGHT _____ SEX _____ ALLERGIES _____

ALLERGIC TO DRUGS OR MEDICATION? _____ PENICILLIN? _____

CURRENT MEDICATIONS _____

FOR WHAT SYMPTOMS? _____

BRIEF HISTORY OF MEDICAL PROBLEMS _____

PHYSICIAN'S NAME _____ PHONE # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

IN CASE OF EMERGENCY CONTACT:

1. NAME _____ PHONE # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

2. NAME _____ PHONE # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

3. NAME _____ PHONE # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

IF I AM TAKING MEDICATION AT THE TIME OF THE RACE/CRUISE, I WILL HAVE A SUPPLY ADEQUATE FOR THE LENGTH OF THE VOYAGE DOUBLED AND ALSO PROPERLY LABELED.

COMMENTS _____

SIGNATURE

DATE

It is suggested that a copy of this profile be given to each one of your emergency contacts.

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