



Medical Profile - International R/V *SIKULIAQ* ~ Seward Marine Center

IDENTIFICATION:

Last Name: (Print) _____ First Name _____

Cruise/Chief Scientist: _____ Role/Title: _____

Date of Birth & Age: _____ Company/Organization: _____

PASSPORT (#, Country, Expiry Date, & Nationality): _____

_____ Gender: _____

Telephone # _____ E-Mail: _____

MEDICAL INFORMATION:

Blood Type (A/B/AB/O) Rh (positive or negative): _____

Medications: _____

Allergies (medications/food/other): _____

Current Medical Problems: _____

Medical History (Major Operations & Procedures – include dates): _____

PRIMARY PERSONAL PHYSICIAN INFORMATION:

Name: _____

Phone: _____

PRIMARY DENTIST INFORMATION:

Name: _____

Phone: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Phone: _____ Alternate Phone: _____

Name: _____ Relationship: _____

Phone: _____ Alternate Phone: _____

Immunization Records

Immunizations marked with an asterisk (*) are required to meet minimum international travel standards. Please provide the most recent date for any of the following immunizations that you have had. One or more of these immunizations may be recommended for people traveling to “high risk” areas of the world.

Primary Childhood Immunizations

Diphtheria-Tetanus-Pertussis (DPT)	Yes	No
Polio	Yes	No
Mumps-Measles-Rubella (MMR)	Yes	No

Primary Adult Immunizations	Date Received	Secondary Immunizations	Date Received
*Diphtheria/Tetanus (dT)		Cholera	
*Polio (over age 18)		Japanese Encephalitis	
*Measles (over age 18)		Initial	
*Hepatitis A (over age 18)		Day 7	
First in series		Day 30	
Second in series		Meningococcal	
Booster		Rabies	
Hepatitis B		Typhoid	
First in series		Oral Typhoid	
Second in series		Typherix (injection)	
Third in series		Typhim Vi (injection)	
Booster		Wyeth Typhoid (injection)	
Varicella		Yellow Fever	
TB Skin Test		Malaria Prophylaxis	
Influenza (Flu)		Gammaglobulin (GG/IG)	
Pneumococcal		Other:	
Rubella		Other:	

To the best of my knowledge, the above Medical History Information is accurate and complete. I authorize release of this information to the Master R/V SIKULIAQ (SKQ) and Marine Superintendent and/or Port Captain – Seward Marine Center (UAF-SMC). In the event of a medical incident, I authorize (SKQ) to release the information set forth in this form to George Washington-Maritime Medical Access (GW-MMA) and health care providers as it may deem necessary; and I authorize SKQ or GW-MMA to notify the persons listed under “Emergency Contact” of the occurrence and nature of the incident, recommended medical treatment, and from whom further information may be obtained. GW-MMA may, at its sole discretion, request assistance for me from an international assistance provider or refer my care directly to a physician and/or hospital and/or other medical provider. GW-MMA may require that any health care provider set forth in the previous sentence furnish reports on my status to GW-MMA or the international assistance provider.

By completing and returning this form, I agree to the above two statements.

Signature

Date

Send it electronically to: skqmarinesup@sfos.uaf.edu