



Guest Passage / Youth Sail Training Application

****One Participant per Application****

Pages 1-4 must be returned together to reserve passage.

- * STUDENTS: Please attach a copy of a recent school physical or complete page 5 (Physical Exam).
- * ADULTS: Physical Exam (page 5) is required only for offshore passages.
- * If required, Physical Exam (Page 5) must be submitted at least two weeks prior to passage.

Mail or fax to:

Virginia Maritime Heritage Foundation
 500 E. Main Street, Ste 600
 Norfolk, Virginia 23510
 Phone: 757-627-7400 Fax: 757-627-8300

Name: _____
(first) (MI) (last)

Address: _____

City: _____ State: _____ Zip: _____

Phone: (day) _____ (Evening) _____ Fax: _____

Cell Phone: _____ (Please provide both land line & cell numbers if available)

Email Address: _____

Age _____ Height _____ Weight _____ Gender _____

I am interested in the following passage:

1st Choice Date: _____ Cost: \$ _____

2nd Choice Date: _____ Cost: \$ _____

A 50% deposit is required to hold your reservation. Payment may be by check accompanying this application or via credit card. **Unless other arrangements have been made**, final payment must be received (two) weeks before departure of your passage, either by check or it will be deducted from your provided credit card.

Circle One: Visa Master Card / Circle One: Deposit Final Payment Full Balance

Account Number: _____

V Code: _____ Expiration Date: _____ Amount to be Charged: _____

Name (as it appears on card) _____

Credit Card Billing Address: _____
(if different than above)

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____



Emergency Contact Information

Name: _____
(first) (MI) (last)

Adult Guests

Emergency Contact Information:

Name of Emergency Contact(s) *please provide 2 contacts:*

Name: _____ Relationship: _____

Home #:() _____ Cell #:() _____ Work #:() _____

Name: _____ Relationship: _____

Home #:() _____ Cell #:() _____ Work #:() _____

Youth Sail Training Student

Parent / Guardian Emergency Contact Information:

We realize that students have different circumstances. Please fill out the information as it applies to the student's situation.

Mother:

First Name: _____ Last Name: _____

Street Address _____ City _____ Zip _____

Home #:() _____ Cell #:() _____ Work #:() _____

Father:

First Name: _____ Last Name: _____

Street Address _____ City _____ Zip _____

Home #:() _____ Cell #:() _____ Work #:() _____

Guardian: (please indicate relationship if applicable) _____

First Name: _____ Last Name: _____

Street Address _____ City _____ Zip _____

Home #:() _____ Cell #:() _____ Work #:() _____



Medical Information

Name: _____ DOB: _____
(first) (MI) (last)

Insurance Information

Name of policy Holder _____

Address _____

City _____ State _____ Zip _____

Insurance Company Name _____

Type of Insurance _____ Policy # _____

Medical History *(to be filled out by parent or guardian for passengers under 18)*

A copy of this form should be taken to your physical exam for physician's review.

- | Yes | No | |
|-----|-----|---|
| ___ | ___ | 1. Have you ever had any of the following? Please explain YES answers. (Use back of form if needed) |
| ___ | ___ | heart murmur _____ |
| ___ | ___ | high blood pressure _____ |
| ___ | ___ | other heart problems _____ |
| ___ | ___ | broken bones _____ |
| ___ | ___ | weak joints-ankles, knees _____ |
| ___ | ___ | concussion _____ |
| ___ | ___ | operation(s) _____ |
| ___ | ___ | seizures/epilepsy _____ |
| ___ | ___ | 2. Have you ever fainted or passed out? Why? _____ |
| ___ | ___ | 3. Have you ever been knocked out? _____ |
| ___ | ___ | 4. Have you ever been hospitalized? _____ |
| ___ | ___ | 5. Have you ever had to stop running after ¼ to ½ mile for chest pain or shortness of breath? _____ |
| ___ | ___ | 6. Do you have any allergies? |
| ___ | ___ | a. Bee stings – On medication? _____ |
| ___ | ___ | b. foods _____ |
| ___ | ___ | c. medicine _____ |
| ___ | ___ | d. other _____ |
| ___ | ___ | 7. Do you have asthma? |
| ___ | ___ | A. What triggers your asthma? _____ |
| ___ | ___ | B. What medications are you taking? _____ |
| ___ | ___ | 8. Have you been recently treated for any illnesses lasting a week or more such as mononucleosis? _____ |
| ___ | ___ | 9. Have you had any blood disorders, including sickle cell trait, anemia, etc? _____ |
| ___ | ___ | 10. Do you wear contact lenses or eye glasses? _____ |
| ___ | ___ | 11. Do you have any missing or non-functioning organs such as eye, kidney, etc? _____ |
| ___ | ___ | 12. Have you recently had any instances or trouble with sleepwalking? _____ |
| ___ | ___ | 13. Do you have any other significant health problems? _____ |
| ___ | ___ | 14. Do you use prescription medicines regularly? <i>please list</i> _____ |
| ___ | ___ | 15. Do you use any over the counter medicines regularly? <i>please list</i> _____ |
| ___ | ___ | 16. Have you had any hospital stays, surgeries or emergency room/urgent care visits within the last 60 days? <i>please list</i> _____ |

Date of last tetanus immunization? _____

By signing below, I certify that to the best of my knowledge the information contained in this document is correct and accurate.

Signature: _____ Date: _____

Parent/Guardian Signature*: _____ Date: _____

*(*if passenger is under 18)*

*** Please attach a current record of immunization history if participant is less than 18 yrs of age ***



Physical Exam

(To be completed by physician, physician assistant or nurse practitioner)

Guidelines for licensed physician, physician assistant, or nurse practitioner.

The Virginia Maritime Heritage Foundation requires a physical examination / certification of any participants intending to sail on offshore or international passages aboard the schooner *Virginia*.

Understanding that it could take 3 hours or more for the participant to reach a medical facility, physicians should evaluate participants based on medical history and guidelines of the physical demands listed below:

Physical demands that a participant must be capable of handling:

- *Standing for periods of 1-4 hours.
- *Rapidly donning an exposure suit and/or personal floatation device.
- *Maintaining balance on a moving deck.
- *Pulling or lifting heavy objects a minimum of 25lbs.
- *Stepping over doorsills of 24 inches in height.
- *Climbing steep stairs or vertical ladders without assistance.
- *Repetitious movements of arms, and/or legs (pulling lines)
- *Treading water for a minimum of 10 minutes.
- *Working in cramped spaces on rolling vessels.
- *Temperatures between 40 to 100 degrees.

Name of participant: _____ DOB: _____

Gender: _____ Age: _____ Height: _____ Weight: _____

Eye color: _____ Hair color: _____ Distinguishing Marks: _____

Date of last tetanus immunization? _____

BP: _____ Pulse (rest) _____ (Exercise) _____ (Recovery) _____

Vision: Corrected (L) _____ (R) _____ Field of vision: ___ Normal

Uncorrected (L) _____ (R) _____ ___ Abnormal

Color Blind? ___ Yes ___ No (distinguishes red, green, yellow, blue)

Hearing: Is the participant's hearing capability impaired? ___ Yes ___ No

If yes, please explain _____

Musculoskeletal:

Cervical spine/neck _____ Back _____ Shoulders _____

Arm/elbow/wrist/hand _____ Knees/hips _____ Ankles/feet _____

Respiratory/Circulatory:

Lungs _____ Heart _____ Eyes _____

Ears _____ Nose _____ Throat _____

Does the participant currently suffer from any infectious condition? ___ Yes ___ No

If yes, please explain _____

Has the participant ever suffered from or been treated for any of the following:

- ___ Yes ___ No Psychiatric disorder
- ___ Yes ___ No Alcohol abuse
- ___ Yes ___ No Depression
- ___ Yes ___ No Drug abuse
- ___ Yes ___ No Attempted suicide
- ___ Yes ___ No Loss of memory

Considering the findings in this examination, and noting the physical demands that may be placed upon the participant during passage aboard *Virginia*, I consider the participant: (Please check one)

_____ Competent _____ Not Competent _____ Needs Further Review

Physician Signature:* _____ Date: _____

** Doctor of Medicine, Doctor of Osteopathy or Licensed Nurse Practitioner*

Physician Name: (print) _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____