



Trainee Application

One Participant per Application

Page 1 of the application packet must be returned together with a deposit 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 30 days 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 of Trainee: _____
(first) (MI) (last)

Address: _____

City: _____ State: _____ Zip: _____

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

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

Email Address: _____

Date of Birth: _____ Gender: _____

I am interested in the following passage:

Date: _____ Cost: \$ _____

A 50% deposit is required to hold your reservation. Payment may be by check or credit card. Final payment must be received 30 days before departure of your passage.

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

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 of card holder: _____ Date: _____



Release of Liability with Acknowledgement of Responsibility and Safety while aboard schooner *Virginia*

I, _____, in consideration
(first) (MI) (last)

of passage on the sailing vessel *Virginia*, furnish the following acknowledgement concerning my responsibility and safety as a trainee:

As a trainee, my responsibility is to obey the orders and policies of the Captain, officers and crew of the vessel; and, to remain in designated areas when requested to do so. I also acknowledge that compliance with safety regulations and other precautions does not guarantee against injuries, deaths, and vessel sinking at sea. I understand that sailing can be a dangerous activity, and I hereby willingly assume any and all risk (including loss of life) to my property or my person, and on behalf of myself and my personal representatives, agree to hold harmless Virginia Maritime Heritage Foundation, its Directors, Officers, Employees, agents and *Virginia* from and against any liability for any such injury or death, save and except for any such claim which results from the negligence or willful misconduct of the Virginia Maritime Heritage Foundation, its employees, agents and representatives, or any negligent acts or omissions in connection with the proper maintenance of *Virginia*.

Signature and Date

Signature of Parent or Guardian if Trainee is less than 18 yrs of age

Witness

Schooner *Virginia* Photo Release Agreement

This confirms the Agreement between you and the Virginia Maritime Heritage Foundation (VMHF) regarding participation in VMHF sail training programs and the photography that is an integral part of this experience.

As part of our effort to provide excellent communication with the relatives and friends of sailing program participants, the crew of Schooner *Virginia* routinely takes digital photos and occasional videos while underway. We are able to post these photos and videos on our web site.

By signing this Agreement, you grant to the VMHF the exclusive right to post these photos on our web site and the right to use these photos in our newsletters, public relations printed material, advertisements, and general correspondence.

The VMHF will not distribute these photos to any entity outside of our organization.

Signature and Date

Signature of Parent or Guardian if Trainee is less than 18 yrs of age

Witness



Emergency Contact Information

Name of Trainee: _____
(First) (MI) (Last)

Name of Emergency Contact: *(Please provide 2 contacts. If trainee is under 18 years of age, at least one emergency contact must be a parent or guardian.)*

Name: _____ Relationship: _____

Address: _____ City/State: _____ Zip: _____

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

Name: _____ Relationship: _____

Address: _____ City/State: _____ Zip: _____

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

Swimming Participation Form

The Virginia Maritime Heritage Foundation has a Swim Policy for the safety of trainees during passage aboard the schooner *Virginia*. The policy requires that this form be completed and signed prior to participating in swimming activities while a trainee aboard the ship.

Name of Trainee: _____
First MI Last

I am confident that I am able to swim in open waters; furthermore, I am confident that I am able to stay afloat, unassisted, for a minimum of 30 minutes.

Trainee Signature

Date

If Trainee is less than 18 years old:

I am confident that my child is able to swim in open waters and is able to stay afloat, unassisted, for a minimum of 30 minutes. I give permission for my child to participate in swimming activities while a trainee aboard schooner *Virginia*.

Parent/Guardian Signature

Date



Medical Information

Name of Trainee: _____ DOB: _____
(First) (MI) (Last)
 Height: _____ Weight: _____ Gender: _____

Medical History *(to be filled out by parent or guardian if trainee is 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 <u>YES</u> 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? Why? _____ |
| ___ | ___ | 3. Have you ever been knocked unconscious? _____ |
| ___ | ___ | 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 anemia, sickle cell disease, 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 ever walked in your sleep? _____ |
| ___ | ___ | 13. Do you have any other 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? _____

Please attach a current record of immunization history, if trainee is less than 18 years of age.

Insurance Information *(please print)*

Name of Policy Holder: _____ Relationship to Trainee: _____
 Address _____
 City _____ State _____ Zip _____
 Insurance Company Name _____
 Type of Insurance _____ Policy # _____

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 trainee is under 18)*



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 for any trainee under the age of 18, as well as for adult trainees 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 the physical requirements listed below:

Physical requirements for trainees:

- *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. *Working in a variety of weather conditions and temperature extremes

Name of trainee: _____ 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: _____



Student Transportation Form

(required for trainees under the age of 18 only)

Please fill out the following information on your student's transportation to and from the vessel. This will allow us to know when to expect your student and how they are getting home.

Travel to Vessel Itinerary:

Type of transportation to port city: _____
(i.e. name of airline or bus service)

Arrival Date: _____ Arrival time: _____ Flight #: _____

Type of Transportation to vessel: _____
(i.e., taxi, shuttle)

For Cars:

Name of authorized parent/guardian dropping off student: _____

Contact phone #(s): _____

Travel from Vessel Itinerary:

Departure Date: _____ Departure Time: _____ Flight #: _____

Type of Transportation from vessel: _____
(i.e., taxi, airport shuttle)

For Cars:

Name of authorized parent/guardian picking up student: _____

Contact phone #(s): _____

Additional Information: _____

Office Use Only

Name of Student: _____

Port: _____

Dock Location: _____

Date of Trip: _____