

LIVING CLASSROOMS FOUNDATION
CENTER FOR MARITIME STUDIES
MEDICAL INFORMATION FORM
To be completed by Parent or Guardian

Course Section _____

Last Name	First Name	M.I.
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Street Address	City/Town	Zip
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_____-_____-_____
Social Security Number

NAMES OF LEGAL GUARDIANS:

_____ Home # (____) _____ Work # (____) _____
_____ Home # (____) _____ Work # (____) _____

EMERGENCY INFORMATION: If you cannot be reached with the above information, please designate a contact in case of emergency:

Name _____ Relationship to Student _____

Address _____

Home # (____) _____ Work # (____) _____

Parental Release: I give permission for authorized personnel to carry out such emergency diagnostic and therapeutic procedures as may be necessary for my son / daughter, and also permit such procedures to be carried out at, and by the local hospital(s) in the event that my son / daughter has been taken there for emergency care. I understand tat any medical expenses will be directly billed to me or my insurance company.

Parent / Guardian signature	Date
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ALL STUDENTS MYST HAVE INSURANCE IN ORDER TO PARTICIPATE

Name of Insurance Company _____

Policy Number _____

Group Number _____ ID Number _____

LIVING CLASSROOM FOUNDATION
CENTER FOR MARITIME STUDIES
HEALTH CERTIFICATE
To be completed by Parent or Guardian

Please complete that following information.

Has the applicant had the following:

Chicken pox_____	Asthma_____	Hepatitis_____	Migraine_____
Diabetes_____	Mumps_____	Epilepsy_____	Severe stomach aches_____
Sleep walking_____	Dizziness / fainting_____	Skin condition_____	Menstrual cramps_____
Sinusitis_____	Earaches_____	Heart condition_____	

Are there other medical problems that we should know about?

Is the applicant fully immunized? Yes_____ No_____

Year of last Tetanus Toxoid Booster:_____

Are there any special dietary needs we should know about?

Does the applicant require any regular medication or medical treatment?

Note: All medications, prescription and non-prescription are given to the Director at the start of the course. Written instructions must accompany such medications so that they may be given to the student as required.

Note: Smoking or other use of tobacco products, or consumption of alcoholic beverages while involved in Living Classrooms Programs on board ship or ashore is prohibited.

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PHYSICAL CONDITION
To be completed by Parent or Guardian

PLEASE NOTE!!!

A full disclosure of any regular medication your child may require or any physical or emotional problems he / she might have, not already noted on the student medical form, is imperative to allow time to take necessary precautions to accommodate your child.

MEDICAL BACKGROUND

Is there any additional information about your child (medical, behavioral, etc.) that you feel we should know that will assist us in providing an enjoyable and safe experience?

Student's age _____ Date of Birth _____ Place of Birth _____

Sex _____ Height _____ Weight _____

PARENTAL PERMISSION

I hereby grant permission for (state name of minor) _____ to board Foundation vessels for educational purposes and around the Inner Harbor. I agree to release and forever discharge the Living Classrooms Foundation, Inc, its Officers, Board of Trustees, Employees and Agents, its Officers and Crew (hereinafter "Released Parties") from any and all liability, damages, claims or causes of action, arising out of or in anyway connected with the minor's boarding or participation in the expedition. I further agree to indemnify and hold forever harmless liability, damages, claims or causes of action made or brought by he said minor or by anyone on behalf of the minor as a result of or in any way connected with the minor's boarding participation in the program.

Parent / Guardian signature

Date

LIVING CLASSROOM FOUNDATION, INC.
ADULT WAIVER

I agree to release and forever discharge the Living Classrooms Foundation, Inc, its Officers, Board of trustees, Employees and Agents, and all vessels and facilities owned and/or operated by Living Classrooms (hereinafter "Released Parties") from any and all liability, damages, claims or causes of action, arising out of or in any way with my boarding or participation in the Living Classrooms programs or any transportation or unnamed visitations. I acknowledge that the Living Classrooms Foundations reserves the right to video, photograph, or record any activity associated with this educational trip. I further agree to indemnify and hold forever harmless liability, damages, claims or causes of action made or brought on by myself or by anyone as a result of or in any way connected with my boarding or participation in the expedition.

Date _____ Signature _____

Date of Trip _____ Address _____

Phone # (____) _____ City, State, Zip _____

Group _____

Please have all adults attending the program sign a copy of this waiver and bring it on the day of your program.