R/V *ATLANTIC EXPLORER* Medical Information Form
Please complete & submit ELECTRONICALLY

Title. Full Name and Pronouns _____ **Assigned Sex** _____ **Gender** _____
(SURNAME, GIVEN NAME & MIDDLE NAME, PRONOUNS)

Medical Information:

Current Medications (dosage and frequency) _____

_____

Allergies (medications, foods, other) _____

Current and Past Medical Conditions _____

Past History (Major Operations & Procedures, include dates) _____

Healthcare Providers Information:

Primary Physician (Name and Contact #) _____

Dentist (Name and Contact #) _____

Immunization Records

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

Primary Adult	Date	Secondary Adult	Date
Diphtheria / Tetanus (dT)		Typhoid (if recommended) Choose one:	
Polio		Oral Typhoid	
Measles		Typhim Vi (injection)	
Hepatitis A (after age 18)		Wyeth Typhoid (injection)	
First in Series		Yellow Fever	
Second in Series or Booster		Meningococcal	
Hepatitis B (after age 18 if no previous immunization		Japanese Encephalitis	
First in Series		Rabies	
Second in Series		Pre-exposure	
Third in Series or Booster		Post-exposure	
Varicella		Cholera	
TB Skin Test		Malaria Prophylaxis	
Influenza (Flu)		Other	
Pneumococcal			
Rubella			

Signature _____ **Date** _____