

<i>Medical Forms & Instructions</i>	Title:	Prepared By: S. Brittner	Revision No: 5	Section: 509
		Approved By:	Edited:	Page:
		R. Harelstad	10/08/2012	1 of 3

MAS Medical Profile (International Travel) Form Instructions

UNOLS vessels typically operate far from the availability and level of medical help people usually take for granted ashore. Individual crew members and scientists must therefore take personal responsibility for their health and safety as much as possible during their time on board. While we make every effort to provide a safe ship and work environment, it must be recognized that work at sea is inherently dangerous. If you become sick or injured at sea it is often critical that your medical history and information is complete, up-to-date and available to the medical personnel and caregivers assisting you.

Research vessels seldom carry a doctor and crew members have minimal first aid training and expertise. For this reason, UNOLS contracts with Medical Advisory Systems (MAS), a division of MedAire, Inc., an organization that provides 24/7 access to medical doctors specializing in ship and aircraft medical emergencies through the INMARSAT system or via Sat Phone. The ship carries an inventory of medical supplies recommended by MAS so that MAS doctors can provide directions to the care-givers on board for managing the particular emergency.

Filling out and submitting this form is voluntary. However, this information is intended to allow the MAS doctors to provide quick response to any medical emergency you may experience. It is intended for your protection.

Due to privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), no copy will be reviewed at BIOS. It is recommended but not required that you give a copy to the captain at the beginning of your cruise or on an annual basis if you make frequent cruises. If you wish to bring a copy aboard in your personal possession that is your choice.



Medical Advisory Systems
Maritime Service



Medical Profile (International Travel)

CREW MEMBER IDENTIFICATION:

Name: _____ Passport #: _____ Country: _____

Date of Birth: _____ Social Security #: _____

Vessel Name: _____

UNOLS Organization: _____ Phone: _____

Fax: _____ E-Mail: _____

Address: _____

Contact Person: _____

MEDICAL INFORMATION:

Current Medications: _____

Allergies - Medications /foods /other: _____

Current Medical Problems: _____

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

Blood Type /Positive or Negative: _____

PERSONAL PHYSICIAN INFORMATION:

Name: _____

Phone: _____ FAX: _____

DENTIST INFORMATION

Name: _____

Phone: _____ FAX: _____

EMERGENCY NOTIFICATION PURPOSES - EMERGENCY CONTACT (only contacted after UNOLS)

Name: _____ Relationship: _____

Phone: _____ Alternate Phone: _____

Medical Advisory Systems, A Service of MedAire
80 East Rio Salado Parkway, Suite 610, Tempe, Arizona 85281
Maritime Services Phone: (480) 333-3700 Maritime Services Fax: (480) 333- 3821
Medical Emergency Phone: (480) 333-3876 E-mail: followup@mas1.com

PRINT DATE 4/25/2006

MAS, A Service of MedAire
 REV: 04/18/206

Medical Profile Form

SLD 01-11/RO
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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.

IMMUNIZATIONS

PRIMARY CHILDHOOD

Diphtheria-Tetanus-Pertussis (DPT)	YES	NO
Polio	YES	NO
Mumps-Measles-Rubella (MMR)	YES	NO

PRIMARY ADULT	Date Rec'd	SECONDARY ADULT	Date Rec'd
*Diphtheria /Tetanus (dT)		Typhoid (if recommended) Choose 1	
*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-if had pre-exposure immunization	
Varicella		Post-exposure - if did not have any immunization	
TB Skin Test		Cholera	
Influenza (Flu)		Malaria Prophylaxis	
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 Medical Advisory Systems.

In the event of a medical incident, I authorize Medical Advisory Systems to release the information set forth in this form to such health care providers as it may deem necessary; and I direct Medical Advisory Services to notify the persons listed under "For Emergency Notification Purposes" of the occurrence and nature of the incident, recommend medical treatment, and from whom further information may be obtained. Medical Advisory Services may, in 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. Medical Advisory Systems may require that any health care provider set forth in the previous sentence furnish reports on my status to Medical Advisory Systems or the international assistance provider. By completing and returning this form, I agree to the above two statements.

SIGNATURE

DATE