MAS
A SERVICE OF MEDAIRE, INC.

*Medical Advisory Systems*
*Maritime Service*


# Medical Profile (International Travel)

**CREWMEMBER 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/food/other: _____

Current Medical Problems: _____

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

_____

Blood Type / Rh 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: _____

**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 IMMUNIZATIONS**

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

| **PRIMARY ADULT IMMUNIZATIONS** | **Date Received** | **SECONDARY IMMUNIZATIONS** | **Date Received** |
|---|---|---|---|
| *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 Systems to notify the persons listed under "For Emergency Notification Purposes" of the occurrence and nature of the incident, recommended medical treatment, and from whom further information may be obtained. Medical Advisory Systems 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 _____

**Please return to the address below:**

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