



S/V DENIS SULLIVAN SCIENCE UNDER SAIL Application Packet

Welcome to S/V Denis Sullivan's Science Under Sail program! In this application packet you will find information to help you or your child prepare for adventure on the water with the *S/V Denis Sullivan*, as well as the forms that are required to be filled out completely, signed, and returned to Discovery World at least *two weeks* before the program starts in order to participate.

Send your fully completed application packet back by one of these methods!

Program Kenosha Community Sailing Center / KTS 19

Start Date/Time July 29, 2019, 0900

Start Location Milwaukee

End Date August 1, 2019, 1600

End Location Kenosha

Amount Due Per Contract

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EMAIL

completed, signed
application packet to:
**reservations@
discoveryworld.org**

FAX

completed, signed
application packet
with a cover page to:
**Discovery World
(Attn: Reservations)
at 414-765-0311**

MAIL

completed, signed
application packet to:
**Discovery World
Attn: Reservations
500 N. Harbor Dr.
Milwaukee, WI 53202**

ABOUT SCIENCE UNDER SAIL

Science Under Sail is a unique and amazing opportunity. Students will be able to explore life on the water from the decks of an 1800's-era styled three-masted schooner and get a first-hand education in marine biology, ecology, navigation, traditional sailing and maritime legacy.

However, the *S/V Denis Sullivan* is not a cruise vessel – it is a working sea vessel where participation in the ship's daily duties is expected. Participants will be working alongside professional crew on rotating watches through a 24-hour cycle. Some operations on the ship require demanding physical activity. The ship may spend part of its voyage a considerable distance from emergency medical assistance. Therefore, it is important that the participant and the participant's parent or guardian read through this application packet carefully and fill out every form fully. Given enough lead-time, Discovery World can ensure that the ship is prepared to accommodate some medical conditions and physical limitations. Discovery World, however, must reserve the right at any time to decline participation to anyone with medical or physical problems that could create a potentially dangerous situation to participant, crew or vessel at sea.

The *S/V Denis Sullivan* is large and stable, and meets or exceeds all applicable U.S. Coast Guard and FCC regulations. She is inspected annually by the American Bureau of Shipping and the U.S. Coast Guard, and carries all required safety equipment.

Before boarding the ship, participants will assemble on the dock to meet the captain and crew, and discuss the participation expectations during the voyage. Participants will be divided into watch groups and assigned to a mate who will be their supervisor for the duration of the voyage. On board, they will receive a safety orientation informing them of appropriate and inappropriate behavior, potential hazards, and the locations of emergency equipment as well as vessel familiarization training. They will be assigned a bunk for sleeping and storing their personal and emergency equipment. Participants will regularly have opportunities to ask questions and are encouraged to do so.

Please read over the packing list and make sure that you have all of the equipment the participant will want or need on the voyage. Please also double-check that the participant has whatever medical materials they will need for the duration of the voyage. Pets of any kind are not permitted on the ship.

PACKING LIST

Space is limited on the ship. Thus, it is important to plan accordingly. All items brought will be stowed inside your bunk space, in addition to provided personal emergency gear. Pack everything in a duffle bag or something soft. There are no laundry facilities on board.

If your starting or ending port is outside the USA, you must have a valid passport!

RECOMMEND CLOTHING

- 1 pair of closed toe shoes, i.e. sneakers or boots
- 1 pair of sandals or flip-flops
- 2-3 pairs of socks
- 1-2 pairs of pants (waterproof optional)
- 1 pair of shorts
- 3-4 shirts (long & short sleeve)
- Sweatshirt or fleece
- Pajamas
- Swimsuit
- Underwear for each day
- Long underwear
- Hat with a brim
- 1 pair of gloves
- Warm jacket
- Waterproof foul weather gear

Even if the weather is warm on land, it can be 10-15 degrees cooler on the lake, and even colder at night. Prepare for cool weather. Layers are best!

ADDITIONAL ITEMS

- Day backpack
- Wristwatch
- Water bottle with carabiner
- Book/Kindle or music player *with headphones*
- Headlamp or flashlight
- Identification

PERSONAL CARE ITEMS

- Toiletries (including soap & shampoo; environmentally safe is best)
- Towel
- Medication
- Vitamins/nutritional supplements
- Additional contacts
- Sunglasses
- Sunscreen & SPF lip balm
- Seasickness medication (if you are prone to seasickness, start taking the day before boarding)

OPTIONAL ITEMS

- Sleeping bag (a sheet, blanket, pillow & pillowcase are provided)
- Extra pillow & pillowcase
- Extra blanket
- Cellphone with charger
- Camera (other than on a cellphone)
- Deck of cards
- Journal & pen
- Cash/currency for souvenirs, a possible meal out with tip, etc.

Be advised that the ship can be a harsh environment for sensitive electronics and you bring them at your own risk.

WAIVER OF LIABILITY

Must be signed by participant *and* parent/guardian, if participant is under the age of 18.

This Waiver of Liability (the “Waiver”) is executed on

this ____ day of _____, 20____, by _____ (the “participant”) in favor of DISCOVERY WORLD, INC., a nonprofit corporation organized and existing under the laws of the State of Wisconsin, USA, and its directors, officers, employees, and agents (collectively, “Discovery World”).

I, the participant, desire to voyage with the S/V *Denis Sullivan* and engage in the activities related to being a participant in the Science Under Sail program (“Science Under Sail”). I hereby freely and voluntarily, without duress, execute this Waiver under the following terms:

1. WAIVER AND RELEASE. I, the participant, release and forever discharge and hold harmless Discovery World and its successors and assigns from any and all liability, claims, and demands of whatever kind or nature, either in law or in equity, which arise or may hereafter arise from my participation in Science Under Sail. I understand and acknowledge that this Waiver discharges Discovery World from any liability or claim that I, the participant, may have against Discovery World with respect to bodily injury, personal injury, illness, death, or property damage that may result from my participation in Science Under Sail. I also understand that Discovery World does not assume any responsibility for or obligation to provide financial assistance or other monetary assistance, including but not limited to medical, health or disability insurance, in the event of injury, illness, death or property damage.

2. INSURANCE. I, the participant, understand that I expressly waive any such claim for compensation or liability on the part of Discovery World beyond what may be offered freely by the representative of Discovery World in the event of such injury, medical expense or death.

3. MEDICAL TREATMENT. I understand that, to participate in Science Under Sail, I must be in good physical condition and sound psychological health. To this end, I must obtain prior medical clearance as per the instructions on the Medical Record form in this application. When I arrive at the start of the program, I must inform Discovery World if anything has changed since the Medical Record was submitted. If I fail to fully disclose medical conditions, I may be required to withdraw from the program.

I understand that there are no medical professionals aboard the S/V *Denis Sullivan*. In the event of a medical emergency, I grant permission for the Captain, Acting Captain, or Chief Mate of the S/V *Denis Sullivan* to: 1) authorize medical, dental, or hospital attention to be given, including administering medications listed in the Medical Record in this packet if I am unable to administer them, and 2) to provide the information contained within the Medical Record to a healthcare professional when medical attention is sought.

I hereby release and forever discharge Discovery World from any claim whatsoever which arises or may hereafter arise on account of any first-aid treatment or other

medical services rendered in connection with an emergency during my time in Science Under Sail.

4. ASSUMPTION OF RISK. I understand that going to sea remains, as it has always been, a potentially hazardous endeavor, with the risk of collision, running aground, flooding, capsizing, and fire, among others. The risk of personal injury is enhanced by many factors, including confined spaces, the pitching and rolling of the vessel, and working with lines under tension and with equipment that has moving parts. Stress, fatigue, and the effects of weather can increase personal anxiety or the risk of human error and magnify the consequences of such errors. Acute seasickness may produce physical debility, or magnify or disguise other medical symptoms. I hereby expressly and specifically assume the risk of injury or harm, and release Discovery World from all liability for injury, illness, death, or property damage, resulting from participation in Science Under Sail.

I recognize that the Captain and professional crew are trained to be aware of the safety of everyone aboard the ship, and that I am required to follow their lawful instructions at all times. For my safety, the Captain has complete authority on the ship. Discovery World and the Captain have discretion to determine who they will take to sea, and, if any problem arises, who may continue to participate in the voyage. I understand that, if I am asked to leave the program, I will be responsible for all financial costs involved, including the cost of return airfare and/or evacuation expenses.

5. PHOTOGRAPHY RELEASE. I grant and convey unto Discovery World all right, title, and interest in any and all photographic images and video or audio recordings made by Discovery World during my participation in Science Under Sail, including, but not limited to, any royalties, proceeds, or other benefits derived from such photographs or recordings.

6. BREADTH, FORUM AND VALIDITY. I expressly agree that this Waiver is intended to be as broad and inclusive as permitted by the laws of the State of Wisconsin in the United States of America, and that this Waiver shall be governed by and interpreted in accordance with the laws of the State of Wisconsin. I agree that in the event that any clause or provision of this Waiver shall be held to be invalid by any court of competent jurisdiction, the invalidity of such clause or provision shall not otherwise affect the remaining provisions of this Waiver, which shall continue to be enforceable.

By signing below, you are certifying that you have read and understand the information in the Waiver of Liability and agree to its provisions.

Must be signed by participant *and* parent/guardian, if participant is under the age of 18.

PARTICIPANT'S PRINTED NAME

PARTICIPANT'S SIGNATURE

DATE

PARENT/GUARDIAN'S PRINTED NAME

PARENT/GUARDIAN'S SIGNATURE

DATE

CONDUCT AGREEMENT

Must be signed by participant and parent/guardian, if participant is under the age of 18.

Science Under Sail is a terrific opportunity! That opportunity comes with responsibility. Please read and sign this conduct agreement to demonstrate that you understand what will be expected of you in Science Under Sail.

BEHAVIOR. Safety is our primary concern out on the water. If the participant behaves unsafely, through intent or ignorance, they create a dangerous situation for themselves, other participants, and the crew. Be alert, and listen carefully to instructions and orders from the Captain and crew.

PARTICIPATION. The *S/V Denis Sullivan* is a working schooner, and participation in the daily activities of the vessel is expected. Most things on the vessel are not automatic. Sails are raised and lowered by hand. The anchor is dropped and pulled up by the crew and participants. Steering the vessel is manual and we do not have cruise control to set a course. Participants will participate in every component of the voyage. It is hard work and physically demanding to be a crew member. However, overcoming this yields a reward like no other.

CO-ED ACCOMODATIONS. The ship environment is co-ed unless otherwise arranged, and all activities occur in co-ed groups. Participants sleep in a co-ed hold in separate bunks, and have little privacy except in the heads (bathrooms). No participant will be treated differently because of their gender, and no harassment or abuse of any kind by anyone on board will be tolerated.

CELLPHONE. Depending on the group, cellphone use may be permitted when not on watch duty. However, cell service is not always available on the water. Furthermore, in order to conserve energy the ship will not always be available to charge cellphones. If you are not currently using your cellphone, simply power it down and leave it in your bunk.

MEALS. A full time cook on board will prepare breakfast, lunch and dinner each day. Overnight snacks may be provided for watches. Snacks are available between meals. Since over 30 people will be eating meals, please be mindful of what you put on your plate by keeping your portion small initially. There will be options for second (or even third) helpings, but finish what is on your plate first. We do not waste food on board.

CONSERVATION. The ship is like a floating village: It is our water source, our food source, our energy source. It is our everything. Thus, it is essential to remember that we have a finite supply of resources. For example, we do not leave the sink running when we wash dishes, because that may mean no water for boiling pasta later in the week. We turn off lights when we are not in our bunks so that we don't use fuel from the tanks. Our goal of conservation on the ship translates to our everyday lives.

By signing below, you are certifying that you have read and understand the information provided in the Science Under Sail application packet and agree to the provisions in the Conduct Agreement.

Must be signed by participant *and* parent/guardian, if participant is under the age of 18.

 PARTICIPANT'S PRINTED NAME

 PARTICIPANT'S SIGNATURE

 DATE

 PARENT/GUARDIAN'S PRINTED NAME

 PARENT/GUARDIAN'S SIGNATURE

 DATE

PARTICIPANT INFORMATION

Full Name _____

Sail Starting Port _____ Start Date _____

Sail End Port _____ End Date _____

Passport Number _____ *(if either port is outside of the USA)*

Passport Issuing Country _____ Passport Expiration _____

Date of Birth _____

Street Address _____

Apt./Suite _____

City _____ State _____ Zip _____

Phone Number _____

Email _____

Dietary Restrictions _____

Other Concerns _____

EMERGENCY CONTACTS

(If the participant is under the age of 18, one of the Emergency Contacts listed below shall be the same parent/guardian that signed the Waiver of Liability or Conduct Agreement)

Name _____

Phone Number _____ Mobile? Yes No

Relationship to Participant _____

Name _____

Phone Number _____ Mobile? Yes No

Relationship to Participant _____

MEDICAL RECORD

(PAGE 1 OF 5)

CONFIDENTIAL

This form (5 pages) MUST be completed by a Medical Professional.

Please complete EVERY section of the Medical Record. If a field is not applicable, write N/A; do not leave it blank. An incomplete Medical Record WILL delay and potentially disqualify participation.

The S/V *Denis Sullivan* may spend a portion of the voyage a long distance from emergency medical assistance. It is essential that we know now of any condition that poses a risk of sudden incapacitation or debilitating complication, and any condition requiring medication which may affect the participant’s physical or mental abilities while on the vessel.

In most cases Discovery World can ensure that the ship is prepared to accommodate medical conditions and physical limitations. However, Discovery World reserves the right at any time to decline participation to anyone with medical or physical problems that could create a dangerous situation to participant, crew or ship.

For your convenience, the common and essential tasks a participant will be asked to be able to perform aboard the *Sullivan* are described on page 11 of this application packet, *Physical Abilities and Access to Care*.

Participant’s Name _____		
FIRST	MIDDLE INITIAL	LAST
Date of Birth _____/_____/_____	Height (ft, in) _____	Weight (lbs.) _____
MONTH DAY YEAR		
Gender: Male Female Other	Blood Pressure ____/____	Pulse (resting) _____

MEDICAL RECORD

(PAGE 2 OF 5)

CONFIDENTIAL

Participant's Name _____
FIRST
MIDDLE INITIAL
LAST

Does the participant currently have, or have they ever suffered from, any of the following in the last 2 years? Complete every question.

	YES	NO		YES	NO		YES	NO
Glaucoma or cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric disorder	<input type="checkbox"/>	<input type="checkbox"/>
Other vision problems	<input type="checkbox"/>	<input type="checkbox"/>	Speech impairment	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Suicide attempt/Ideation	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease / MI	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric counseling	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Substance abuse or dependency	<input type="checkbox"/>	<input type="checkbox"/>
Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Sleep apnea/Narcolepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Impaired balance	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Impaired ROM of limbs	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or passing out	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disorders	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Renal problems	<input type="checkbox"/>	<input type="checkbox"/>	Amputation/Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Urinary tract disorders	<input type="checkbox"/>	<input type="checkbox"/>	Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	Seizures / Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Immunosuppression	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss / Dementia	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding or clotting disorders	<input type="checkbox"/>	<input type="checkbox"/>	Gastric ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Other permanent disability	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes or ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea/Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco or alcohol use	<input type="checkbox"/>	<input type="checkbox"/>

If "YES" was checked for any of the above items, please explain:

Does the participant have a known immunity to Rubeoloa, Rubella, and/or is the participant free of Active Tuberculosis? Yes No

Has the participant had their last Tetanus Toxoid within the past 10 years? Yes No

Is the participant pregnant, or could the participant be pregnant? N/A Yes No

MEDICAL RECORD

(PAGE 4 OF 5)

CONFIDENTIAL

PHYSICAL ABILITIES AND ACCESS TO CARE

A Reference for the Examining Medical Professional

The S/V *Denis Sullivan* is a 130 ft. long wooden-hulled ship constructed in the authentic style of an 1800's Great Lakes cargo schooner. While sailing, participants aboard the vessel may be away from harbors offering medical services for extended periods and will have access to fundamental medical care only. Medical evacuation may not always be possible. Participants will be in an environment which is physically and emotionally demanding. Please examine this list of required tasks when making your evaluation.

REQUIRED TASK	THE PARTICIPANT MUST
Movement on slippery, uneven and unstable surfaces	Have no disturbance in sense of balance
Access between levels	Be able to climb up and down vertical ladders and stairways
Movement between compartments	Be able to step over an 18 inch barrier and duck under 36 inches
Open and close watertight doors, hand cranks and valves	Be able to turn wheels vertically and horizontally, maneuver 55 pound hatches, and be able to comfortably rotate wrists and reach above shoulders
Handle ship's stores	Be able to lift a 20 pound load off the ground, and to carry, push or pull the same load
Vessel maintenance	Be able to crouch without discomfort for several minutes or more, and grasp, lift and manipulate tools
Fire emergency response, including escaping smoke-filled spaces	Be able to kneel and crawl, distinguish temperature by feel, and carry and handle fire hoses and extinguishers
Abandon ship	Be able to don a personal flotation device and an exposure suit without assistance
Stand watch	Be able to alertly stand for up to 6 hours with minimal rest
React to visual alarms	Have a visual acuity of at least 20/40 with or without correction, and be able to distinguish shapes at a distance
Make verbal reports or raise vocal alarms	Be able to describe immediate surroundings and activities in English, with clear enunciation and raised voice

MEDICAL RECORD

(PAGE 5 OF 5)

CONFIDENTIAL

Participant's Name _____
FIRST MIDDLE INITIAL LAST

SUMMARY OF FINDINGS

Considering the findings in this examination, and noting the duties the participant will be asked to perform aboard the *S/V Denis Sullivan* (as described on page 11 of this packet, *Physical Abilities and Access to Care*), I make the following determination:

- Do not recommend participation
- Recommend participation
- Recommend participation with the following restrictions:

Signature of Examiner _____ Date _____

Medical Facility _____

Medical Facility Street Address _____

Medical Facility City, State, Zip Code _____

TO BE COMPLETED BY THE PARTICIPANT, AND PARENT/GUARDIAN IF PARTICIPANT IS UNDER THE AGE OF 18.

I certify that all medical information provided by me is complete and true to the best of my knowledge.

Signature of Participant _____ Date _____

Print Full Name _____

Signature of Parent/Guardian _____ Date _____

Print Full Name _____

Privacy Statement: All medical information submitted to Discovery World Ltd. on this medical report is for the sole use of Discovery World Ltd, its medical advisors for the purposes of evaluating the physical condition of applicants, and by emergency medical personnel and doctors in case of injury or illness. This document will be kept on file at the Discovery World Ltd. office for a period of one year from date signed and then destroyed.

POWER OF ATTORNEY FOR CONSENT TO MEDICAL CARE

By signing this form, I (we) hereby authorize the S/V Denis Sullivan's Captain, Acting Captain, or Chief Mate to consent to any medical care and treatment for _____ (participant) that is recommended by a licensed healthcare provider to whom the participant is presented for treatment, and to release any medical record information to a healthcare professional in furtherance of treatment. In order to ensure that the participant receives prompt medical care and treatment when necessary, I (we) hereby release any licensed health care provider providing medical care to the participant in reliance of this form from liability relating to such provider's acceptance of my (our) substitute care giver's consent.

This Power of Attorney is dated _____ and is valid for one year.

PARTICIPANT'S SIGNATURE	DATE	PARENT'S SIGNATURE, IF PARTICIPANT IS UNDER THE AGE OF 18	DATE
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WITNESS'S SIGNATURE	DATE	2ND WITNESS'S SIGNATURE	DATE
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* Witnesses cannot be: **(a)** Related to the participant by blood, marriage, or adoption, or the domestic partner, under Ch. 770, Wis. Stats., of the participant; **(b)** Have knowledge that he or she is entitled to or has a claim on any portion of the participant's estate; **(c)** Directly financially responsible for the participant's health care; **(d)** An individual who is a health care provider who is serving the participant at the time of execution, an employee, other than a chaplain or a social worker, of the health care provider or an employee, other than a chaplain or a social worker, of an inpatient health care facility in which the participant is a patient; or **(e)** The participant's health care agent. Ch. 155, Wis. Stats.

MEDICAL HISTORY

Failure to complete any of the following does not impair the validity of this Power of Attorney for consent to medical care.

PARTICIPANT'S NAME	BIRTH DATE	ALLERGIES
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RELIGION	BLOOD TYPE	DATE OF LAST TETANUS SHOT
----------	------------	---------------------------

PREVIOUS HOSPITALIZATIONS AND MAJOR ILLNESSES	CURRENT MEDICATIONS
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PHYSICIAN	TELEPHONE	OTHER IMPORTANT INFORMATION
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PARENT INFORMATION, IF PARTICIPANT IS UNDER THE AGE OF 18

FATHER'S NAME	HOME PHONE	HOME ADDRESS
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PLACE OF EMPLOYMENT	WORK PHONE
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INSURANCE COMPANY	POLICY NUMBER
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PARENT INFORMATION, IF PARTICIPANT IS UNDER THE AGE OF 18

MOTHER'S NAME

HOME PHONE

HOME ADDRESS

PLACE OF EMPLOYMENT

WORK PHONE

INSURANCE COMPANY

POLICY NUMBER

NOTICE TO PERSON MAKING THIS DOCUMENT: YOU HAVE THE RIGHT TO MAKE DECISIONS ABOUT YOUR HEALTH CARE. NO HEALTH CARE MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND NECESSARY HEALTH CARE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT.

BECAUSE YOUR HEALTH CARE PROVIDERS IN SOME CASES MAY NOT HAVE HAD THE OPPORTUNITY TO ESTABLISH A LONG-TERM RELATIONSHIP WITH YOU, THEY ARE OFTEN UNFAMILIAR WITH YOUR BELIEFS AND VALUES AND THE DETAILS OF YOUR FAMILY RELATIONSHIPS. THIS POSES A PROBLEM IF YOU BECOME PHYSICALLY OR MENTALLY UNABLE TO MAKE DECISIONS ABOUT YOUR HEALTH CARE.

IN ORDER TO AVOID THIS PROBLEM, YOU MAY SIGN THIS LEGAL DOCUMENT TO SPECIFY THE PERSON WHOM YOU WANT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU ARE UNABLE TO MAKE THOSE DECISIONS PERSONALLY. THAT PERSON IS KNOWN AS YOUR HEALTH CARE AGENT. YOU SHOULD TAKE SOME TIME TO DISCUSS YOUR THOUGHTS AND BELIEFS ABOUT MEDICAL TREATMENT WITH THE PERSON OR PERSONS WHOM YOU HAVE SPECIFIED. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF HEALTH CARE THAT YOU DO OR DO NOT DESIRE, AND YOU MAY LIMIT THE AUTHORITY OF YOUR HEALTH CARE AGENT. IF YOUR HEALTH CARE AGENT IS UNAWARE OF YOUR DESIRES WITH RESPECT TO A PARTICULAR HEALTH CARE DECISION, HE OR SHE IS REQUIRED TO DETERMINE WHAT WOULD BE IN YOUR BEST INTERESTS IN MAKING THE DECISION.

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT GIVES YOUR AGENT BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. IT REVOKES ANY PRIOR POWER OF ATTORNEY FOR HEALTH CARE THAT YOU MAY HAVE MADE. IF YOU WISH TO CHANGE YOUR POWER OF ATTORNEY FOR HEALTH CARE, YOU MAY REVOKE THIS DOCUMENT AT ANY TIME BY DESTROYING IT, BY DIRECTING ANOTHER PERSON TO DESTROY IT IN YOUR PRESENCE, BY SIGNING A WRITTEN AND DATED STATEMENT OR BY STATING THAT IT IS REVOKED IN THE PRESENCE OF TWO WITNESSES. IF YOU REVOKE, YOU SHOULD NOTIFY YOUR AGENT, YOUR HEALTH CARE PROVIDERS AND ANY OTHER PERSON TO WHOM YOU HAVE GIVEN A COPY. IF YOUR AGENT IS YOUR SPOUSE OR DOMESTIC PARTNER AND YOUR MARRIAGE IS ANNULLED OR YOU ARE DIVORCED OR THE DOMESTIC PARTNERSHIP IS TERMINATED AFTER SIGNING THIS DOCUMENT, THE DOCUMENT IS INVALID.

YOU MAY ALSO USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT UPON YOUR DEATH. IF YOU USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT, THIS DOCUMENT REVOKES ANY PRIOR RECORD OF GIFT THAT YOU MAY HAVE MADE. YOU MAY REVOKE OR CHANGE ANY ANATOMICAL GIFT THAT YOU MAKE BY THIS DOCUMENT BY CROSSING OUT THE ANATOMICAL GIFTS PROVISION IN THIS DOCUMENT.

DO NOT SIGN THIS DOCUMENT UNLESS YOU CLEARLY UNDERSTAND IT.

IT IS SUGGESTED THAT YOU KEEP THE ORIGINAL OF THIS DOCUMENT ON FILE WITH YOUR PHYSICIAN.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD

By signing this Authorization, you are authorizing *S/V Denis Sullivan* to disclose your medical records provided in the Science Under Sail application.

Name: _____ Date of Birth: _____

I authorize *S/V Denis Sullivan* to release my entire Medical Record contained in the Science Under Sail Application packet for treatment purposes in the event a medical emergency occurs while I am onboard the *S/V Denis Sullivan*.

This Authorization expires at the conclusion of my time onboard the *S/V Denis Sullivan*.

Signature of Participant _____ Date _____

Signature of Parent/Guardian _____ Date _____
if participant is under the age of 18