

TBI Officer Information and Release Form

2005 Summer Season



Please complete and return all forms to the office

NAME: _____

ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

DATE OF BIRTH: _____ CURRENT AGE: _____ MALE: FEMALE:
(DD/MM/YY)

HOME PHONE: (____) _____ OFFICER E-MAIL: _____

PARENT/GUARDIAN NAME: _____

(IF DIFFERENT FROM ABOVE)

ADDRESS: _____

HOME PHONE: (____) _____ (STREET) _____ (CITY) _____ (PROVINCE.) _____ (POSTAL CODE) _____
WORK PHONE: (____) _____ CELLULAR: _____

PARENT E-MAIL: _____

ALTERNATE EMERGENCY CONTACT: _____

HOME PHONE: (____) _____ WORK PHONE: (____) _____ CELLULAR: _____

Because the ship occasionally visits United States ports, the following information is required:

PLACE OF BIRTH: _____

CITIZENSHIP: _____

ONTARIO HEALTH CARD # _____

CANADIANS MUST BRING ORIGINAL BIRTH CERTIFICATES. NON-CANADIANS MUST HAVE AN AMERICAN VISA, VALID PASSPORT OR LANDED IMMIGRANT PAPERS FOR TRIPS TO THE STATES. THESE PAPERS MUST BE WITH YOU.

General Declaration and Release

I am familiar with the nature and content of Toronto Brigantine's program. I desire that my son/daughter/ward, _____ (OFFICER'S NAME) to participate in the full program and all its activities. I consent to Toronto Brigantine Inc.

using all photographs in which my son/daughter/ward may appear, while enrolled as a program participant, for promotional or other related purposes. In consideration of the participation of my son/daughter/ward in the Toronto Brigantine program, I, personally and on behalf of my son/daughter/ward, release and forever discharge Toronto Brigantine, its employees or agents, from all claims, demands, actions, or causes of action including claims for personal injury, sickness, or property damage that may occur involving my son/daughter/ward while engaged in the Toronto Brigantine program.

I also give my permission for Toronto Brigantine to contact the physician named below (see over) if more medical information is required. In case of a medical emergency, I give my permission for the employees and agents of Toronto Brigantine to administer first aid, and if I am not available for consultation, to select a physician who will secure proper medical treatment (including examination, medication, treatment, anaesthesia or surgery) for my above named son/daughter/ward. I also agree to be responsible for any expenses incurred, including the cost of delivering my son/daughter/ward from the Toronto Brigantine program to medical facilities.

DATE: _____

PARENT/GUARDIAN SIGNATURE: _____

Health Information

PHYSICIAN'S NAME: _____ PHONE: _____

PHYSICIAN'S ADDRESS: _____

WEIGHT _____ HEIGHT _____

HAS THIS TRAINEE HAD ANY OF THE FOLLOWING?

ASTHMA ___ HEPATITIS ___ MIGRAINE ___ DIABETES ___ EPILEPSY OR SEIZURES ___ DIZZINESS/FAINTING ___
SINUSITIS ___ HEART CONDITION ___ CHICKEN POX ___ MUMPS ___ EARACHES ___ SKIN CONDITION ___
SEVERE STOMACH ACHES ___ SLEEP WALKING ___ MENSTRUAL CRAMPS ___

ARE THERE ANY OTHER HEALTH PROBLEMS THAT WE SHOULD KNOW ABOUT?

IS THIS TRAINEE AFRAID IF HEIGHTS? YES ___ NO ___ NOT SURE ___
DOES THIS TRAINEE HAVE NORMAL HEARING? YES ___ NO ___
IF NO, DOES THE TRAINEE USE A HEARING AID? YES ___ NO ___
DOES THIS TRAINEE HAVE NORMAL VISION WITH OR WITHOUT CORRECTIVE GLASSES OR CONTACT LENSES? YES ___ NO ___
DOES THIS TRAINEE WEAR EYEGLASSES? YES ___ NO ___
DOES THIS TRAINEE WEAR CONTACT LENSES? YES ___ NO ___
IS THIS TRAINEE FULLY IMMUNIZED? YES ___ NO ___
DATE OF LAST TETANUS TOXOID BOOSTER: _____

DOES THIS TRAINEE HAVE ANY ALLERGIES? PLEASE LIST ANY KNOWN ALLERGIES AND IDENTIFY ANY HISTORY OF SERIOUS ALLERGIC REACTIONS.

DOES THIS TRAINEE REQUIRE ANY REGULAR MEDICATION OR MEDICAL TREATMENT?

Note: All medication, prescription and non-prescription, are given to the captain for safekeeping. **Written instructions must accompany such medications so that they may be given to the trainee as required.**

OTHER NOTES _____

