Dear Participant:

We welcome you to the International Ocean Discovery Program and look forward to your participation in exploring new scientific discoveries aboard the *JOIDES Resolution*. In preparation for your stay aboard the ship, we are asking you to provide your personal imedical history information and to meet with your physician to review your present health status. This requirement is to protect your health and safety, since you will be working in confine quarters aboard the ship. There is a medical facility and a full time physician aboard the ship, but the facility is limited. Please complete and return the requested information to the International Ocean Discovery Program no later than June 12, 2017.

PRE-CRUISE PHYSICAL EXAMINATION REQUIREMENTS:

Attachment 1: **Medical Questionnaire**
To be completed by participant.

Attachment 2: **Physician's Instruction**
To be reviewed by physician.

Attachment 3: **Physician's Statement of Release**
To be completed by physician.

Attachment 4: **IODP Cruise Participant Emergency Contact Form**
To be completed by participant.

NOTE: Please be assured that all medical information will be treated confidentially.

NOTE: Enclosed are two letters regarding the Drug Free Workplace Act of 1998 and IODP's Insurance Policy on personal items brought aboard the ship. Please read both letters carefully, and if you have any questions, feel free to contact us.

For additional information, please contact:

Human Resources Representative
Telephone: 979-845-2583
Fax: 979-845-1026

Texas A&M University/International Ocean Discovery Program
Medical History Questionnaire
-To Be Completed By Patient-

Attachment 1

Date: _____

Name: _____ Age: _____ Sex: M F

Address: _____

_____

Phone: _____ Your Present Job Title: _____

How would you rate your physical condition?

☐ Poor ☐ Fair ☐ Good ☐ Excellent

Please read and sign the below statement.

I agree that prior to participating on an IODP cruise I will undergo medical review by a duly licensed physician and that all of the required medical examination forms and attachments will be submitted to the assigned IODP official who will in turn forward these documents to the shipboard doctor. I understand that the doctor must approve the results of my medical review before I can participate in the cruise. I understand that I am responsible for providing all medication and medical supplies which I may need for the treatment of existing conditions for the duration of my time aboard the ship. I certify that the answers given by me on this questionnaire are true, complete, and correct to the best of my knowledge.

_____ _____

Participant Signature Date

To the best of your knowledge, have you ever had or now have symptoms or a diagnosis of any of the following? Please check all that apply.

- ☐ Hernia, skin disorder, or fungus infections.
- ☐ Problems with the stomach, intestine, throat, esophagus, ulcers, or digestive disorder.
- ☐ Gallbladder disease, hepatitis, jaundice, or other liver disease.
- ☐ Asthma, allergies, bronchitis, pneumonia, emphysema, sinus, nasal, tonsils, adenoids, bronchi, trachea, lung, or other respiratory symptoms.
- ☐ Abnormal growth or function of thyroid, pancreas, adrenal, or lymph glands.
- ☐ Diabetes, anemia, or other blood disorders.
- ☐ Problems with the kidneys, bladder, prostate, reproductive organs, menstrual disturbance, or other male/female disorder.
- ☐ Arthritis, rheumatism, polio, rheumatic fever.
- ☐ Cancer, leukemia, Hodgkin's disease, or Kaposi' Sarcoma.
- ☐ Injury or problem with the back, muscle, bone, joint, spine, neck; fracture or deformity
- ☐ Tumor, cyst, or growth (benign/malignant); disease or lump(s) in breast.
- ☐ Impairment of sight or hearing, cataracts, or ear infections.
- ☐ Gain or loss of more than 10-15 pounds in the past year or obesity.
- ☐ Any past or present complications of pregnancy (prior history of miscarriage, infertility, toxemia, c-section) or is any person now pregnant?
- ☐ Any other medical or surgical advice, treatment, or hospitalization.
- ☐ Any chronic or recurring minor ailments, injuries, or other departures from good health, regardless of whether or not a practioner was consulted.
- ☐ High or low blood pressure, stroke, heart trouble, heart defect, murmur, or other circulatory impairment of blood, arteries.

Please check if any of the following factors have been or are present in your history:

- ☐ Smoker, if so # of packs a day _____
- ☐ High blood pressure
- ☐ Elevated cholesterol levels
- ☐ Sedentary lifestyle coupled with a physically demanding job
- ☐ Elevated cholesterol levels
- ☐ History of heart attack or sudden cardiac death in a first degree relative less than 60 years of age.

For those questions you checked, please describe the medical or surgical care advised or performed, the date of illness or treatment and your present condition, in the space provided below. _____

_____

_____

_____

_____

Are you presently taking medication, including psychotropic medication? ☐ Yes ☐ No

Please explain: _____

_____

_____

Do you have a history of sea sickness or other types of motion sickness? ☐ Yes ☐ No

Each cruise participant is encouraged to discuss the possibility of sea/motion sickness with his/her physician. The physician can provide information or prescribe medications to prevent or control the symptoms. Participants with concerns about sea/motion sickness should also discuss their situation with the ship's physician as soon as possible after boarding.

Have you been ill, injured, hospitalized, or under the care of a physician for physical and/or emotional problems within the last six months? ☐ Yes ☐ No

Please explain: _____

_____

_____

Have you been treated for or under the care of a physician/psychologist for depression, mental illness, and/or emotional problems in the last 12 months? If yes, please explain providing details including dates, medication prescribed for condition, and prognosis.

_____

_____

_____

_____

Blood Type _____ (Please attach copy of medical record indicating blood type, such as blood donor card, previous blood type results, or physician statement of your blood type.)

Dates of latest immunizations:

*Tetanus _____

Polio _____

Diphtheria _____

Hepatitis B _____

** TB Skin Test _____

Measles, mumps, rubella _____

* Tetanus inoculation is required, if more than 10 years has passed since your last incoulation.

** TB Skin Test is required. If individual received BCG in past, physician statement is needed indicating the individual has had a BCG inoculation. Chest X-Ray is not required; but strongly recommended.

A signed physician's statement is required for all scientific participants of the International Ocean Discovery Program (IODP) research cruise aboard the drill ship *JOIDES Resolution*. The purpose of this statement is to protect the health and safety of this individual, his/her coworkers, and the scientific objectives of the cruise.

Please note that although a licensed physician accompanies all cruises medical facilities on the ship are limited. Although emergency medical evaluation can sometimes be arranged, it is time-consuming and very expensive. Please bear this information in mind in evaluating your patient's ability to withstand participation in the confined quarters of the ship.

The participant has been asked to provide you with a completed IODP medical questionnaire to assist you in making your determination. Please review the completed questionnaire.

Work Environment on the Ship

Participants may assist in the collection and analysis of scientific data. The working Environment would by typical of that in a laboratory or office. While on board the vessel, the participant will encounter the following:

1. Frequent exposure to moving machinery

2. Frequent exposure to changes in temperature and/or humidity.

3. Frequent exposure to dust, fumes, and gases

4. Periods of time spent working in confined quarters

PHYSICIAN'S STATEMENT OF RELEASE

Attachment 3

PHYSICIAN, Please check one:

☐ IT IS MY OPINION THAT THIS PATIENT IS PHYSICALLY CAPABLE OF PERFORMING HIS/HER DUTIES.

☐ THIS PATIENT IS NOT PHYSICALLY CAPABLE OF PERFORMING HIS/HER DUTIES. Please explain below:

☐ THIS PATIENT IS NOT CLEARED TO SAIL PENDING (tests, further review) Please explain below:

_____

_____

_____

_____

This judgement is based on the examination and based on the review of medical questionnaire and the typical physical requirements. I performed this physical exam and hereby certify that I am a duly licensed physician.

Please print or type:

_____ M.D. _____

Signature of Examining Physician Date

Physician Name: _____

Physician Address: _____

_____

Office Telephone Number: _____

Fax Number: _____

PHYSICIAN: The PARTICIPANT must return the Physician's Statement with his signature, completed Medical Questionnaire, and the Emergency Contact Form to:

Human Resources/Insurance Services
CONFIDENTIAL
International Ocean Discovery Program
1000 Discovery Drive
College Station, Texas 77845
Phone# 979-845-2583
Fax# 979-845-1026

INTERNATIONAL OCEAN DISCOVERY PROGRAM
CRUISE PARTICIPANT EMERGENCY CONTACT FORM

Attachment 4

Participant Name: _____ Expedition: _____

Social Security #: _____ Date of Birth: _____

Home Address: _____

_____

Home Phone: _____ Business Phone: _____

IN AN EMERGENCY YOU MAY CONTACT:

Name: _____ Relationship: _____

Address: _____

_____

Home Phone: _____ Business Phone: _____

****

OR:

Name: _____ Relationship: _____

Address: _____

_____

Home Phone: _____ Business Phone: _____

Name: _____ Relationship: _____

Address: _____

_____

Home Phone: _____ Business Phone: _____

****

You have my permission to use this information in an emergency situation.

_____ _____

Participant Signature Date

****

I do not wish to provide the information requested above.

_____ _____

Participant Signature Date