Disney Cruise Line Medical Examination Form

Last/Family Name	First/Given Name	Middle Initial
Date of Birth (dd/mm/yyyy)	Sex ❒ Male ❒ Female	Passport/Discharge Book No.
Home Address _____		

Examinee's personal declaration (Assistance should be offered by medical staff):

Have you ever had any of the following conditions?

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
Eye/vision problem	❒	❒	High Blood Pressure	❒	❒	Balance problem	❒	❒
Do you smoke?	❒	❒	Heart/vascular disease	❒	❒	Operation/surgery	❒	❒
Heart surgery	❒	❒	Epilepsy/seizures	❒	❒	Varicose veins	❒	❒
Dizziness/fainting	❒	❒	Asthma/bronchitis	❒	❒	Loss of consciousness	❒	❒
Psychiatric problems	❒	❒	Blood Disorder	❒	❒	Diabetes	❒	❒
Depression	❒	❒	Thyroid problem	❒	❒	Digestive disorder	❒	❒
Attempted suicide	❒	❒	Loss of memory	❒	❒	Kidney problem	❒	❒
Sleep problems	❒	❒	Skin problem	❒	❒	Severe headaches	❒	❒
Allergies	❒	❒	Ear/Nose/Throat problems	❒	❒	Infectious/Contagious diseases	❒	❒
Restricted mobility	❒	❒	Hernia	❒	❒	Back problem	❒	❒
Genital disorders	❒	❒	Amputation	❒	❒	Pregnancy	❒	❒
Fractures/dislocations	❒	❒	Tuberculosis	❒	❒	Cancer	❒	❒
Abnormal smears/painful periods (females)				❒	❒			

Have you ever been signed off as sick or repatriated from a ship?	❒	❒
Have you ever been hospitalized?	❒	❒
Have you ever been declared unfit for sea duty?	❒	❒
Has your medical certificate ever been restricted or revoked?	❒	❒
Do you currently have any medical problems, diseases or illnesses?	❒	❒
Do you feel healthy and fit to perform the duties of your designated position/occupation?	❒	❒

If any of the above questions were answered "yes", please give details:

Please list any medications to which you are allergic:

Please list any non-prescription or prescription medications you are currently taking, including the purpose(s) and dosage(s):

I hereby certify that the personal declaration above is true and accurate to the best of my knowledge.

Examinee: _____ Signature

Date (dd/mm/yyyy): _____ / _____ / _____

Examiner: _____ Signature

Date (dd/mm/yyyy): _____ / _____ / _____

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Last/Family Name: _____First/Given Name: _____

Height:		(cm)	Weight:		(kg)		
Pulse Rate		(/(minute)	Rhythm:		Temperature		
Blood Pressure	Systolic:		(mm Hg)	Diastolic:			(mm Hg)

	Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
Head	❒	❒	Eye Movement	❒	❒	Vascular (inc. pedal pulses)	❒	❒
Sinuses, nose, throat	❒	❒	Lungs & Chest	❒	❒	Abdomen and viscera	❒	❒
Mouth/teeth	❒	❒	Breast Exam	❒	❒	Hernia	❒	❒
Ears (general)	❒	❒	Heart	❒	❒	Anus (not rectal exam)	❒	❒
Tympanic membrane	❒	❒	Varicose Veins	❒	❒	Upper and lower extremities	❒	❒
Eyes	❒	❒	G-U System	❒	❒	Spine (C/S, T/S and L/S)	❒	❒
Opthalmoscopy	❒	❒	Psychiatric	❒	❒	Neurologic (full brief)	❒	❒
Pupils	❒	❒	Skin	❒	❒	General appearance	❒	❒

Vision	Distance			Near			Visual Fields		
	Right Eye	Left Eye	Binocular	Right Eye	Left Eye	Binocular		Right Eye	Left Eye
Unaided							Normal		
Aided							Defective		

Color Vision	❒	Normal	❒	Abnormal	

Audio								Speech and Whisper	
	Khz	500	1,000	2,000	4,000	6,000	8,000	Normal	Whisper
Right Ear	dB								
Left Ear	dB								

Is Chest X-ray needed: ❒ Yes ❒ No

Indicate Reason: _____

Results: _____

Other Diagnostic test(s) and result(s): Enter results or attach lab report

Blood	Hemoglobin		BUN		Urine	
	Hematocrit		Creatinine		Albumin	
	WBC		Ast/Alt		Glucose	
	Sodium (Na)		Alkaline Phosphatase			
	Potassium(K)		VDRL/RPR			
	Glucose		$HepB_sAg$			

Medical Examiner's comments:

_____

_____

_____

Assessment of fitness for service at sea

On the basis of the examinee's personal declaration, my clinical examination and the diagnostic test results recorded above, I declare the examinee medically:

❒ Fit for duty ❒ Temporarily not fit for duty ❒ Permanently not fit for duty

Place of examination:_____ Date(dd/mm/yyyy): _____/_____/_____

Official stamp (also print name of medical examiner if not legible):

Signature of medical examiner: _____

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Infectious Disease Immunity Verification
(For New Hires only)

Last/Family Name	First/Given Name	Date of Birth (dd/mm/yy)

IMPORTANT NOTE TO COMPLETE THIS FORM

List disease immunity by providing one of the following:
- Dates of the disease
- Immunization dates
- Positive immunity by Titer

Past History		
Disease	**Date (dd/mm/yyyy)**	**Verification**
Mumps		❒ Disease (infection) ❒ Immunization ❒ Titer
Measles		❒ Disease (infection) ❒ Immunization ❒ Titer
Rubella		❒ Disease (infection) ❒ Immunization ❒ Titer
Varicella (Chicken Pox)		❒ Disease (infection) ❒ Immunization ❒ Titer

For all crew, Immunization is required for Mumps, Measles, and Rubella if Disease History or Positive Titer does not verify disease immunity.

For Youth Activities Crew, Immunization is also required for Varicella if Disease History or Positive Titer does not verify disease immunity.

Name of Clinic or Physician (Office Stamp)	Physician Signature	Date (dd/mm/yyyy)

Disney Cruise Line Medical Examination Form

CONSENT FOR HIV / AIDS TEST

NOTE TO DOCTOR/HEALTH CARE PROVIDER:

- **DO NOT perform HIV testing on citizens or residents of the United States.**
- **DO NOT perform HIV testing on the examinee if applicable law in your country/province/state prohibits pre-employment HIV testing.**
- **DO provide the examinee with all required HIV education materials and disclosures, as well as all forms and releases, as required by applicable local law and custom in order to perform HIV testing and provide the results of this test to Disney Cruise Line.**

EXAMINEE'S DECLARATION:

I declare that I am not a citizen or resident of the United States and that I am willing to undergo testing for HIV/AIDS antibodies and consent to the taking of a blood sample for this purpose. I agree to allow the results to be provided to my medical practitioner and Disney Cruise Line.

Examinee's Signature:_____

Name Printed:_____

Date:_____

Witnessed by:_____

Name Printed:_____

Date:_____

SEAFARER'S MEDICAL CERTIFICATE

Disney Cruise Line

Photo

Last/Family Name	First/Given Name	Position applied for

Date of Birth	Sex	Nationality	ID (Passport/Discharge book) No:
DD/MM/YYYY			

I have evaluated the above-named examinee according to medical standards and regulations of The Bahamas (ILO/WHO/D.2/1997 Guidelines for Conducting Pre-Sea and Periodic Medical Examinations of Seafarers), and on the basis of the examinee's personal declaration, my clinical examination, and the diagnostic test results obtained, and in consideration of the essential requirements of the position applied for and state as follows:

(a) in my opinion this employee is **FIT/ NOT FIT** for duty (circle one);
(b) If the examinee is to be employed in the Deck Department, that the hearing, sight and color vision of the examinee are satisfactory; and,
(c) that the examinee is not suffering from any disease likely to be aggravated by, or render him/her unfit for, service at sea or likely to endanger the health of other persons on board ships, and specifically that the examinee is free from all communicable diseases (including without limitation Tuberculosis).

If unfit, state reason:

Visual aid required (specify): Yes/No Informed spares necessary: Yes/No Fit for lookout duty: Yes/No

Clinic stamp:

Physician Signature: _____

Physician Name Printed _____

Date: DD MM YYYY

Authorizing body: BAHAMAS MARITIME AUTHORITY

I acknowledge that I have been advised of the content of the medical examination form.

Examinee's signature: _____

A copy of this page should be kept by the examining physician, and a copy sent to Disney Cruise Line.
The original should be given to the seafarer.