



Medical Statement

PARTICIPANT RECORD — CONFIDENTIAL INFORMATION

Please read carefully before signing.

This is a statement in which you are informed of some potential risks involved in scuba diving and of the conduct required of you during the scuba training program. Your signature on this statement is required for you to participate in the scuba training program offered by:

(INSTRUCTOR) _____

and (FACILITY) _____

located in the city of _____

and state of _____.

Read and discuss this statement prior to signing it. You must complete this Medical Statement, which includes the medical-history section, to enroll in the scuba training program. If you are a minor, you must have this Statement signed by a parent.

Diving is an exciting and demanding activity. When performed correctly, applying correct techniques, it is very safe. When established safety procedures are not followed, however, there are dangers.

To scuba dive safely, you must not be extremely overweight or out of condition. Diving can be strenuous under certain conditions. Your respiratory and circulatory systems must be in good health. All body air spaces must be normal and healthy. A person with heart trouble, a current cold or congestion, epilepsy, asthma, a severe medical problem, or who is under the influence of alcohol or drugs should not dive. If taking medication, consult your doctor and the Instructor before participation in this program. You will also need to learn from the Instructor the important safety rules regarding breathing and equalization while scuba diving. Improper use of scuba equipment can result in serious injury. You must be thoroughly instructed in its use under direct supervision of a qualified Instructor to use it safely.

If you have any additional questions regarding this Medical Statement or the Medical History section, review them with your Instructor before signing.

Medical History

To the Participant:

The purpose of this medical questionnaire is to find out if you should be examined by your doctor before participating in recreational diver training. A positive response to a question does not necessarily disqualify you from diving. A positive response means that there is a preexisting condition that may affect your safety while diving and you must seek the advice of your physician.

Please answer the following questions on your past or present medical history with a **YES** or **NO**. If you are not sure, answer **YES**. If any of these items apply to you, we must request that you consult with a physician prior to participating in scuba diving. Your Instructor will supply you with a medical statement and guidelines for recreational scuba diver's physical examination to take to your physician.

- ____ Could you be pregnant, or are you attempting to become pregnant?
- ____ Are you presently taking precription medications? (with the exception of birth control or anti-malarial)
- ____ Are you over 45 years of age and can answer YES to one or more of the following?
 - currently smoke a pipe, cigars, or cigarettes
 - have a high cholesterol level
 - have a family history of heart attacks or strokes
 - are currently receiving medical care
 - high blood pressure
 - diabetes mellitus, even if controlled by diet alone

HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE...

- ____ Asthma, or wheezing with breathing, or wheezing with exercise?
- ____ Frequent or severe attacks of hayfever or allergy?
- ____ Frequent colds, sinusitis or bronchitis?

- ____ Any form of lung disease?
- ____ Pneumothorax (collapsed lung)?
- ____ Other chest disease or chest surgery?
- ____ Behavioral health, mental or psychological problems (panic attack, fear of closed or open spaces)?
- ____ Epilepsy, seizures, convulsions or take medications to prevent them?
- ____ Recurring migraine headaches or take medications to prevent them?
- ____ Blackouts or fainting (full/partial loss of consciousness)?
- ____ Frequent or severe suffering from motion sickness (seasick, carsick, etc.)?
- ____ Dysentery or dehydration requiring medical intervention?
- ____ Any dive accidents or decompression sickness?
- ____ Inability to perform moderate exercise (example: walk 1.6 km/one mile within 12 mins.)?

- ____ Head injury with loss of consciousness in the past five years?
- ____ Recurrent back problems?
- ____ Back or spinal surgery?
- ____ Diabetes?
- ____ Back, arm or leg problems following surgery, injury or fracture?
- ____ High blood pressure or take medication to control blood pressure?
- ____ Heart disease?
- ____ Heart attack?
- ____ Angina, heart surgery or blood vessel surgery?
- ____ Sinus surgery?
- ____ Ear disease or surgery, hearing loss or problems with balance?
- ____ Recurrent ear problems?
- ____ Bleeding or other blood disorders?
- ____ Hernia?
- ____ Ulcers or ulcer surgery?
- ____ A colostomy or ileostomy?
- ____ Recreational drug use or treatment for, or alcoholism in the past five years?

The information I have provided about my medical history is accurate to the best of my knowledge. I agree to accept responsibility for omissions regarding my failure to disclose any existing or past health condition.

SIGNATURE _____

DATE _____

SIGNATURES OF PARENTS OR GUARDIANS WHERE APPLICABLE _____

DATE _____

Student

(Please print legibly)

Name _____ Birth Date _____ Age _____
First Initial Last

Mailing Address _____

City _____ State/Province _____

Country _____ Zip/Postal Code _____

Home Phone () _____ Business Phone () _____

Telex _____ FAX _____

Name and address of your family or primary care physician:

Physician _____ Clinic/Hospital _____

Address _____ Phone () _____

Date of last physical examination _____

Name of examiner _____ Clinic/Hospital _____

Address _____ Phone () _____

Were you ever required to have a physical for diving? ☐ Yes ☐ No If so, when? _____

Physician

This person is an applicant for training or is presently certified to engage in scuba (self contained underwater breathing apparatus) diving. Your opinion of the applicant's medical fitness for scuba diving is requested. Please review Guidelines for Recreational Scuba Diver's Physical Examination.

Physician's Impression:

☐ I find no medical conditions that I consider incompatible with diving.

☐ I am unable to recommend this individual for diving.

Remarks _____

I have reviewed Guidelines for Recreational Scuba Diver's Physical Examination.

_____, M.D. Date _____
Physician's Signature

Physician _____ Clinic/Hospital _____

Address _____ Phone () _____

MEDICAL STATEMENT

PATIENT RECORD — CONFIDENTIAL INFORMATION

Please read carefully before signing

This is a statement in which you are informed of some potential risks involved in scuba diving and of the conduct required of you during the scuba training program. Your signature on this statement is required for you to participate in the scuba training program offered by:

(Name of Instructor) _____
and (Dive Center) _____
located in the city of _____
and state of _____

Read and discuss this statement prior to signing it. You must complete this Medical Statement, which includes the medical-history section, to enroll in the scuba training program. If you are a minor, you must have this Statement signed by a parent.

Diving is an exciting and demanding activity. When performed correctly, applying correct techniques, it is very safe. When established safety procedures are not followed, however, there are dangers.

To scuba dive safely, you must not be extremely overweight or out of condition. Diving can be strenuous under certain conditions. Your

respiratory and circulatory systems must be in good health. All body air spaces must be normal and healthy. A person with heart trouble, a current cold or congestion, epilepsy, asthma, a severe medical problem, or who is under the influence of alcohol or drugs should not dive. If taking medication, consult your doctor and the Instructor before participation in this program. You will also need to learn from the Instructor the important safety rules regarding breathing and equalization while scuba diving. Improper use of scuba equipment can result in serious injury. You must be thoroughly instructed in its use under direct supervision of a qualified Instructor to use it safely.

If you have any additional questions regarding this Medical Statement or the Medical History section, review them with your Instructor before signing.

MEDICAL HISTORY

To the Participant:

The purpose of this medical questionnaire is to find out if you should be examined by your doctor before participating in recreational diver training. A positive response to a question does not necessarily disqualify you from diving. A positive response means that there is a preexisting condition that may affect your safety while diving and you must seek the advice of your physician. Please answer the following questions on your past or present medical history with a **YES** or **No**. If you are not sure, answer **YES**. If any of these items apply to you, we request that you consult with a physician prior to participating in scuba diving. Your Instructor will supply you with a medical statement and guidelines for recreational scuba diver's physical examination to take to your physician.

- | | | |
|---|--|---|
| _____ Could you be pregnant, or are you attempting to become pregnant? | _____ or allergy? | _____ past five years? |
| _____ Are you presently taking prescription medications? (with the exception of birth control or anti-malarial) | _____ Frequent colds, sinusitis or bronchitis? | _____ Recurrent back problems? |
| _____ Are you over 45 years of age and can answer YES to one or more of the following? | _____ Any form of lung disease? | _____ Back or spinal surgery? |
| • currently smoke a pipe, cigars, or cigarettes | _____ Pneumothorax (collapsed lung)? | _____ Diabetes? |
| • have a high cholesterol level | _____ Other chest disease or chest surgery? | _____ Back, arm or leg problems following surgery, injury or fracture? |
| • have a family history of heart attacks or strokes | _____ Behavioral health, mental or psychological problems (panic attack, fear of closed or open spaces)? | _____ High blood pressure or take medication to control blood pressure? |
| • are currently receiving medical care | _____ Epilepsy, seizures, convulsions or take medications to prevent them? | _____ Heart disease? |
| • high blood pressure | _____ Recurring migraine headaches or take medications to prevent them? | _____ Heart attack? |
| • diabetes mellitus, even if controlled by diet alone | _____ Blackouts or fainting (full/partial loss of consciousness)? | _____ Angina, heart surgery or blood vessel surgery? |
| | _____ Frequent or severe suffering from motion sickness (seasick, carsick, etc.)? | _____ Sinus surgery? |
| | _____ Dysentery or dehydration requiring medical intervention? | _____ Ear disease or surgery, hearing loss or problems with balance? |
| | _____ Any dive accidents or decompression sickness? | _____ Recurrent ear problems? |
| | _____ Inability to perform moderate exercise (example: walk 1.6 km/one mile within 12 mins.)? | _____ Bleeding or other blood disorders? |
| | _____ Head injury with loss of consciousness in the | _____ Hernia? |
| | | _____ Ulcers or ulcer surgery? |
| | | _____ A colostomy or ileostomy? |
| | | _____ Recreational drug use or treatment for, or alcoholism in the past five years? |

Have you ever had or do you currently have ...

- _____ Asthma, or wheezing with breathing, or wheezing with exercise?
- _____ Frequent or severe attacks of hayfever

The information I have provided about my medical history is accurate to the best of my knowledge. I agree to accept responsibility for omissions regarding my failure to disclose any existing or past health condition.

▲ SIGNATURE

▲ DATE (day/month/year)

▲ Parent or Guardian signs here IF STUDENT IS A MINOR

▲ DATE (day/month/year)