



# DiveStyle Booking Form



**milke's**  
UK'S N°1 DIVE STORES

Maiden Lane Centre  
Lower Earley, Reading  
Berks, RG6 3HD

Phone: 0118 926 2288, Fax: 0118 926 9616, Website: www.divestyle.co.uk

Opening Hours: 10am - 6pm Monday to Friday, 9am - 6pm Saturday, late night 8:30pm Wednesday

## PERSONAL DETAILS

Title ..... Forename ..... Surname .....

Address .....

Postcode .....

Daytime Tel ..... Mobile Tel ..... Evening Tel .....

Email Address .....

Date of Birth ..... Current Certification Level .....

## Vital Statistics (for dive kit & suit fitting)

Height		Chest		Waist		Hips		Weight		Shoe	
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## What equipment do you have? (please tick all that apply)

Mask	<input type="checkbox"/>	Pool Fins	<input type="checkbox"/>	Sea Fins	<input type="checkbox"/>	Boots	<input type="checkbox"/>	Cylinder	<input type="checkbox"/>	BCD	<input type="checkbox"/>	Regulator	<input type="checkbox"/>	Weights	<input type="checkbox"/>
Dry Suit	<input type="checkbox"/>	Semi Dry	<input type="checkbox"/>	Full Wetsuit	<input type="checkbox"/>	Shorty Wetsuit	<input type="checkbox"/>	Hood	<input type="checkbox"/>	Gloves	<input type="checkbox"/>	None	<input type="checkbox"/>		<input type="checkbox"/>

How did you hear about DiveStyle? .....

## COURSE DETAILS

Course Title ..... Course Option Number .....

Course Fee ..... Location ..... Course Start Date .....

Deposit/Full Fee ..... Date Paid ..... Crew Pack Issued Date .....

Balance Due ..... Date Paid ..... Course Letter Sent .....

OW Weekend video/DVD number ..... Qualifying Dives Letter Sent .....

Medical Form Completed Yes / No Learning Agreement Completed Yes / No

(The following items also apply beyond Open Water course)

Statement of Risk & Liability Completed Yes / No Statement of Safe Diving Completed Yes / No

Certified Divers Risk Completed Yes / No

## PAYMENT DETAILS

I enclose a cheque (payable to DiveStyle Diving Limited) for the **deposit/full** amount or please charge the full amount to my credit/debit card

Name & address of card holder (if different from above) .....



or switch card number .....

Issue number and/or date of issue ..... Expiry Date ..... Signed .....

# DiveStyle Terms and Conditions

- DiveStyle** reserves the right to vary or cancel, at their discretion, a course or its content, where the circumstances or weather necessitate.
- Payment** must be received 21 days prior to the start of the course.
- Cancellations and Transfers** of course date received more than 21 days before the course will receive a full refund. Cancellations and transfers received less than 21 days before the course will receive no refund. A £40.00 plus VAT administration fee will be charged for transfer of date or course.
- Refunds**. No refunds of any monies paid will be given once a course has started. A course is deemed to start on issue of any course materials or on commencement of training.
- Lost or damaged equipment** (caused by student) must be paid for by the student.

## Divers Medical Questionnaire

### 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 pre-existing condition that may affect your safety while diving and you must seek the advice of your physician prior to engaging in dive activities.

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 RSTC 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 prescription 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 attack or stroke
- 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 hay fever or allergy?

\_\_\_\_ Frequent colds, sinusitis or bronchitis?

\_\_\_\_ Any form of lung disease?

\_\_\_\_ Pneumothorax (collapsed lung)?

\_\_\_\_ Other chest disease or chest surgery?

\_\_\_\_ Behavioural health, mental or psychological problem.

(Panic attack, fear of closed or open spaces)?

\_\_\_\_ Epilepsy, seizures, convulsions or take medications to prevent them?

\_\_\_\_ Recurring complicated 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 medicine 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.**

**I accept the DiveStyle Terms and Conditions.**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date