



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. In addition, if your medical condition changes at any time during your scuba programs it is important that you inform your instructor immediately.

Read this statement prior to signing it. You must complete this Medical Statement, which includes the medical questionnaire section, to enroll in the scuba training program. If you are a minor, you must have this Statement signed by a parent or guardian. Diving is an exciting and demanding activity. When performed correctly, applying correct techniques, it is relatively safe. When established safety procedures are not followed, however, there are increased risks.

To scuba dive safely, you should 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 coronary disease, a current cold or congestion, epilepsy, a severe medical problem or who is under the influence of alcohol or drugs should not dive. If you have asthma, heart disease, other chronic medical conditions or you are taking medications on a regular basis, you should consult your doctor and the instructor before participating in this program, and on a regular basis thereafter upon completion. You will also 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 Questionnaire section, review them with your instructor before signing.

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 preexisting 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 an RSTC Medical Statement and Guidelines for Recreational Scuba Diver's Physical Examination to take to your physician.

- | | | |
|--|--|--|
| <input type="checkbox"/> Could you be pregnant, or are you attempting to become pregnant? | <input type="checkbox"/> Any form of lung disease? | <input type="checkbox"/> Recurrent back problems? |
| <input type="checkbox"/> Are you presently taking prescription medications? (with the exception of birth control or anti-malarial) | <input type="checkbox"/> Pneumothorax (collapsed lung)? | <input type="checkbox"/> Back or spinal surgery? |
| <input type="checkbox"/> Are you over 45 years of age and can answer YES to one or more of the following? | <input type="checkbox"/> Other chest disease or chest surgery? | <input type="checkbox"/> Diabetes? |
| <input type="checkbox"/> currently smoke a pipe, cigars or cigarettes | <input type="checkbox"/> Behavioral health, mental or psychological problems (Panic attack, fear of closed or openspaces)? | <input type="checkbox"/> Back, arm or leg problems following surgery, injury or fracture? |
| <input type="checkbox"/> are currently receiving medical care | <input type="checkbox"/> Epilepsy, seizures, convulsions or take medications to prevent them? | <input type="checkbox"/> High blood pressure or take medicine to control blood pressure? |
| <input type="checkbox"/> have a high cholesterol level | <input type="checkbox"/> Recurring complicated migraine headaches or take medications to prevent them? | <input type="checkbox"/> Heart disease? |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> Blackouts or fainting (full/partial loss of consciousness)? | <input type="checkbox"/> Heart attack? |
| <input type="checkbox"/> have a family history of heart attack or stroke | <input type="checkbox"/> Frequent or severe suffering from motion sickness (seasick, carsick, etc.)? | <input type="checkbox"/> Angina, heart surgery or blood vessel surgery? |
| <input type="checkbox"/> diabetes mellitus, even if controlled by diet alone | <input type="checkbox"/> Dysentery or dehydration requiring medical intervention? | <input type="checkbox"/> Sinus surgery? |
| Have you ever had or do you currently have... | <input type="checkbox"/> Any dive accidents or decompression sickness? | <input type="checkbox"/> Ear disease or surgery, hearing loss or problems with balance? |
| <input type="checkbox"/> Asthma, or wheezing with breathing, or wheezing with exercise? | <input type="checkbox"/> Inability to perform moderate exercise (example: walk 1.6 km/one mile within 12 mins.)? | <input type="checkbox"/> Recurrent ear problems? |
| <input type="checkbox"/> Frequent or severe attacks of hayfever or allergy? | <input type="checkbox"/> Head injury with loss of consciousness in the past five years? | <input type="checkbox"/> Bleeding or other blood disorders? |
| <input type="checkbox"/> Frequent colds, sinusitis or bronchitis? | | <input type="checkbox"/> Hernia? |
| | | <input type="checkbox"/> Ulcers or ulcer surgery ? |
| | | <input type="checkbox"/> A colostomy or ileostomy? |
| | | <input type="checkbox"/> 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 affirm it is my responsibility to inform my instructor of any and all changes to my medical history at any time during my participation in scuba programs. I agree to accept responsibility for omissions regarding my failure to disclose any existing or past health condition, or any changes thereto.

Participant's Signature

Date (Day / Month / Year)

Signature of Parent or Guardian (where applicable)

Date (Day / Month / Year)

STUDENT

Please print legibly.

Name _____ Birth Date _____ Age _____
First Initial Last Day/Month/Year

Mailing Address _____

City _____ State/Province/Region _____

Country _____ Zip/Postal Code _____

Home Phone () _____ Business Phone () _____

Email _____ FAX _____

Name and address of your family physician

Physician _____ Clinic/Hospital _____

Address _____

Date of last physical examination _____

Name of examiner _____ Clinic/Hospital _____

Address _____

Phone () _____ Email _____

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

PHYSICIAN

This person applying 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. There are guidelines attached for your information and reference.

Physician's Impression

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

I am unable to recommend this individual for diving.

Remarks

Physician's Signature or Legal Representative of Medical Practitioner Date _____
Day/Month/Year

Physician _____ Clinic/Hospital _____

Address _____

Phone () _____ Email _____