



Technical Diving International Medical Statement

Participant Record (Confidential Information)

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---- 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

_____ and
Instructor

_____ located in
the _____
Facility

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 your doctor should examine you before participating in recreational dive 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 **EACH ONE** 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 those items apply to you, we must request that you consult with a physician prior to participating in scuba diving.

- | | |
|---|---|
| <input type="checkbox"/> Could you be pregnant or are you attempting to become pregnant? | <input type="checkbox"/> History of blackouts or fainting (full/partial loss of consciousness)? |
| <input type="checkbox"/> Do you regularly take prescription or nonprescription medications? (With the exception of birth control) | <input type="checkbox"/> Do you frequently suffer from motion sickness (seasick, carsick, etc)? |
| <input type="checkbox"/> Are you over 45 years of age and have one or more of the following?
- have a high cholesterol level
- have a family history of heart attacks or strokes | <input type="checkbox"/> History of diving accidents or decompression sickness? |
| Have you ever had or do you currently have: | <input type="checkbox"/> History of recurrent back problems? |
| <input type="checkbox"/> Asthma, or wheezing with breathing, or wheezing with exercise? | <input type="checkbox"/> History of back surgery? |
| <input type="checkbox"/> Frequent or severe attacks of hay fever or allergy? | <input type="checkbox"/> History of back, arm or leg problems following surgery, injury or fracture? |
| <input type="checkbox"/> Frequent colds, sinusitis or bronchitis? | <input type="checkbox"/> Inability to perform moderate exercise (example: walk one mile within 12 minutes)? |
| <input type="checkbox"/> Any form of lung disease? | <input type="checkbox"/> History of high blood pressure or take medicine to control blood pressure? |
| <input type="checkbox"/> Pneumothorax (collapsed lung)? | <input type="checkbox"/> History of any heart disease? |
| <input type="checkbox"/> History of chest surgery? | <input type="checkbox"/> History of heart attacks? |
| <input type="checkbox"/> Claustrophobia or agoraphobia (fear of closed or open spaces)? | <input type="checkbox"/> Angina or heart surgery or blood vessel surgery? |
| <input type="checkbox"/> Behavioral health problems? | <input type="checkbox"/> History of ear or sinus surgery? |
| <input type="checkbox"/> Epilepsy, seizures, convulsions or take medications to prevent them? | <input type="checkbox"/> History of ear disease, hearing loss or problems with balance? |
| <input type="checkbox"/> Recurring migraine headaches or take medications to prevent them? | <input type="checkbox"/> History of problems equalizing (popping) ears with airplane or mountain travel? |
| <input type="checkbox"/> History of diabetes? | <input type="checkbox"/> History of bleeding or other bleeding disorders? |
| | <input type="checkbox"/> History of any type of hernia? |
| | <input type="checkbox"/> History of ulcers or ulcer surgery? |
| | <input type="checkbox"/> History of colostomy? |
| | <input type="checkbox"/> History of drug or alcohol abuse? |

The information I have provided about my medical history is accurate to the best of my knowledge.

Signature

Date

Signatures of Parents or Guardians (Where Applicable)

Date