MEDICAL STATEMENT

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 a doctor before participating in daily diving, and should do so on a regular basis. You should be aware of the important safety rules regarding breathing and equalization while scuba diving. Improper use of scuba equipment can result in serious injury.

The purpose of this medical statement is to find out if you should be examined by a doctor before participating in recreational diving. If you do have one of the medical conditions listed below, this does not necessarily mean you cannot dive but that there is a preexisting condition which could affect your safety while diving and you must seek the advice of a physician before engaging in dive activities.

- Pregnant, or attempting to become pregnant
- Presently taking prescription medications (with the exception of birth control)
- 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

You have had in the past or 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
- Behavioral health, mental or psychological problems (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 or 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

I hereby confirm that I _____ have read through the various medical conditions listed above and to the best of my knowledge do not have a current or previous medical condition such as these that may affect my diving. I agree to accept responsibility for omissions regarding my failure to disclose any existing or past health condition.

_____	_____	_____	_____
Signature	Date	Signature of Parent or Guardian	Date

***** If you do have any of the medical conditions as listed, we do ask you fill out the following sheet *****

****Please fill in the emergency contact information on the back on of this sheet****

DIVER

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 _____

Emergency Contact Informations

Name of the person to contact _____Your relationship with this person (father, friend, etc..)_____

His/her phone number ( ) _____ His/her email _____

His/her mailing address _____

_____

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? _____