MEDICAL STATEMENT

Participant Record (Confidential Information)

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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: ______________________

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 can not 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.

	Yes	No
- Pregnant, or attempting to become pregnant		
- Presently taking prescription medicines (with 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 hearth 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….

	Yes	No
- Asthma, or wheezing with breath, 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		

	Yes	No
- Blackouts of fainting (full/partial loss of consciousness)		
- Frequent or severe suffering from motion sickness (seasick, car 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 min.)		
- 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 bloodpressure		
- 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 (where applicable) ________ Date

***** Please fill in the emergency contact information *****

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: ______________________________

- Please scan & send the filled form to: info@diveoverseas.com or by fax to: 03 5441741