Medical Statement

To the Participant:

You must complete this Medical Statement, which includes the medical history information section, prior to enjoying any recreational scuba diving services.

Its purpose is to inform you wether you should be examined by a physician before participating in recreational diving training. If any of these condidions apply to you, this does not neccessarily disqualify you. It only means that for your own safety, you must seek the advice of a physician prior to participating in recreational scuba diving.

Please acknowledge that you have read and understood the information provoded below by initialling each individual point.

1. YOU MUST CONSULT A PHYSICIAN IF:	**YES or NO**	**Initials**
You are pregnant or you suspect you may be pregnant	☐ ☐	
You regularly take medication (with the exception of birth control)	☐ ☐	
You are over 45 years of age and one of the following apply		
You smoke	☐ ☐	
You have a high cholesterol level	☐ ☐	
2. YOU MUST CONSULT A PHYSICIAN IF YOU EVER HAD	**YES or NO**	**Initials**
Asthma, or wheezing with breathing or exercise	☐ ☐	
Any form of lung disease	☐ ☐	
Pneumothorax (collapsed lung)	☐ ☐	
History of chest surgery	☐ ☐	
Claustrophobia or agoraphobia (fear of closed or open spaces)	☐ ☐	
Epilepsy, seizures, convulsions or take medications to prevent them	☐ ☐	
History of blackouts or fainting (full/partial loss of consciousness)	☐ ☐	
History of diving accidents or decompression sickness	☐ ☐	
History of diabetes	☐ ☐	
History of high blood pressure or take medications to control it	☐ ☐	
History of any heart disease	☐ ☐	
History of ear disease, hearing loss or problems with balance	☐ ☐	
History of thrombosis or blood clotting	☐ ☐	
Psychiatric diseases	☐ ☐	
3. I AM AWARE THAT I COULD BE UNFIT TO DIVE IF I HAVE OR DEVELOP ANY OF THE FOLLOWING CONDITIONS		**Initials**
Cold, sinusitis or breathing problems (e.g. bronchitis, hay fever)		
Acute migraine or headache		
Any kind of surgery within the last 6 weeks		
Under influence of alcohol, drugs or medication effecting the ability to react		
Fever, dizziness, nausea, vomiting and diarrhoea		
Problems equalizing (popping ears)		
Acute gastric ulcers		
Pregnancy		

Name.....
Address.....
.....
Date of Birth.....
I confirm that the answers to the questions above are true and complete.

Signature.....Date.....

Parental/Guardian consent where participant is a minor.

Name of Parent/Guardian*.....*delete as applicable
Address.....
.....
Signature.....Date.....
This declaration is valid for one year from date of signature