



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 offered

by Andy Willett and
Instructor
Sea Urchin Divers located in the
Facility
 city of Steyning and state of West Sussex

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 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.

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 a PADI 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"/> History of diving accidents or decompression sickness? |
| <input type="checkbox"/> Do you regularly take prescription or nonprescription medications? (with the exception of birth control) | <input type="checkbox"/> History of recurrent back problems? |
| <input type="checkbox"/> Are you over 45 years of age and have one or more of the following?
<ul style="list-style-type: none"> • currently smoke a pipe, cigars, or cigarettes • have a high cholesterol level • have a family history of heart attacks or strokes | <input type="checkbox"/> History of back surgery? |
| Have you ever had or do you currently have . . . | <input type="checkbox"/> History of diabetes? |
| <input type="checkbox"/> Asthma, or wheezing with breathing, or wheezing with exercise? | <input type="checkbox"/> History of back, arm or leg problems following surgery, injury or fracture? |
| <input type="checkbox"/> Frequent or severe attacks of hayfever or allergy? | <input type="checkbox"/> Inability to perform moderate exercise (example: walk one mile within 12 minutes)? |
| <input type="checkbox"/> Frequent colds, sinusitis or bronchitis? | <input type="checkbox"/> History of high blood pressure or take medicine to control blood pressure? |
| <input type="checkbox"/> Any form of lung disease? | <input type="checkbox"/> History of any heart disease? |
| <input type="checkbox"/> Pneumothorax (collapsed lung)? | <input type="checkbox"/> History of heart attacks? |
| <input type="checkbox"/> History of chest surgery? | <input type="checkbox"/> Angina or heart surgery or blood vessel surgery? |
| <input type="checkbox"/> Claustrophobia or agoraphobia (fear of closed or open spaces)? | <input type="checkbox"/> History of ear or sinus surgery? |
| <input type="checkbox"/> Behavioral health problems? | <input type="checkbox"/> History of ear disease, hearing loss or problems with balance? |
| <input type="checkbox"/> Epilepsy, seizures, convulsions or take medications to prevent them? | <input type="checkbox"/> History of problems equalizing (popping) ears with airplane or mountain travel? |
| <input type="checkbox"/> Recurring migraine headaches or take medications to prevent them? | <input type="checkbox"/> History of bleeding or other blood disorders? |
| <input type="checkbox"/> History of blackouts or fainting (full/partial loss of consciousness)? | <input type="checkbox"/> History of any type of hernia? |
| <input type="checkbox"/> Do you frequently suffer from motion sickness (seasick, carsick, etc.)? | <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

STUDENT

Please print legibly.

Name _____ Birth Date _____ Age _____
First Initial Last

Mailing Address _____

City _____ State/Province _____

Country _____ Zip/Postal Code _____

Home Phone () _____ Business Phone () _____

Telex _____ FAX _____

Name and address of your family or primary care physician

Physician _____ Clinic/Hospital _____

Address _____ Phone () _____

Date of last physical examination _____

Name of examiner _____ Clinic/Hospital _____

Address _____ Phone () _____

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

PHYSICIAN

This person is an applicant 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. Please review Guidelines for Recreational Scuba Diver's Physical Examination.

Physician's Impression

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

I am unable to recommend this individual for diving.

Remarks _____

I have reviewed Guidelines for Recreational Scuba Diver's Physical Examination.

_____, M.D. Date _____
Physician's Signature

Physician _____ Clinic/Hospital _____

Address _____

Phone () _____