



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 _____ 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 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.

- ____ Could you be pregnant or are you attempting to become pregnant?
- ____ Do you regularly take prescription or nonprescription medications?
(with the exception of birth control)
- ____ Are you over 45 years of age *and* have one or more of the following?
 - currently smoke a pipe, cigars, or cigarettes
 - have a high cholesterol level
 - have a family history of heart attacks or strokes

- ____ Do you frequently suffer from motion sickness (seasick, carsick, etc.)?
- ____ History of diving accidents or decompression sickness?
- ____ History of recurrent back problems?
- ____ History of back surgery?
- ____ History of diabetes?
- ____ History of back, arm or leg problems following surgery, injury or fracture?
- ____ Inability to perform moderate exercise (example: walk one mile within 12 minutes)?
- ____ History of high blood pressure or take medicine to control blood pressure?
- ____ History of any heart disease?
- ____ History of heart attacks?
- ____ Angina or heart surgery or blood vessel surgery?
- ____ History of ear or sinus surgery?
- ____ History of ear disease, hearing loss or problems with balance?
- ____ History of problems equalizing (popping) ears with airplane or mountain travel?
- ____ History of bleeding or other blood disorders?
- ____ History of any type of hernia?
- ____ History of ulcers or ulcer surgery?
- ____ History of colostomy?
- ____ History of drug or alcohol abuse?

Have you ever had or do you currently have . . .

- ____ Asthma, or wheezing with breathing, or wheezing with exercise?
- ____ Frequent or severe attacks of hayfever or allergy?
- ____ Frequent colds, sinusitis or bronchitis?
- ____ Any form of lung disease?
- ____ Pneumothorax (collapsed lung)?
- ____ History of chest surgery?
- ____ Claustrophobia or agoraphobia (fear of closed or open spaces)?
- ____ Behavioral health problems?
- ____ Epilepsy, seizures, convulsions or take medications to prevent them?
- ____ Recurring migraine headaches or take medications to prevent them?
- ____ History of blackouts or fainting (full/partial loss of consciousness)?

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

Participant's Signature

Date (day/month/year)

Signatures of Parent or Guardian (where applicable)

Date (day/month/year)