

# 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:

(INSTRUCTOR) High Plains Scuba Staff  
 and (FACILITY) High Plains Scuba Center  
 located in the city of Fort Collins  
 and state of Colorado

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 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"/> Any form of lung disease?  | <input type="checkbox"/> Head injury with loss of consciousness in the past five years?                |
| <input type="checkbox"/> Are you presently taking prescription medications? (with the exception of birth control or anti-malarial) | <input type="checkbox"/> Pneumothorax (collapsed lung)?   | <input type="checkbox"/> Recurrent back problems?  |
| <input type="checkbox"/> Are you over 45 years of age and can answer YES to one or more of the following?                          | <input type="checkbox"/> Other chest disease or chest surgery?  | <input type="checkbox"/> Back or spinal surgery?   |
| <input type="checkbox"/> currently smoke a pipe, cigars, or cigarettes   | <input type="checkbox"/> Behavioral health, mental or psychological problems (panic attack, fear of closed or open spaces)? | <input type="checkbox"/> Diabetes?   |
| <input type="checkbox"/> have a high cholesterol level   | <input type="checkbox"/> Epilepsy, seizures, convulsions or take medications to prevent them?                               | <input type="checkbox"/> Back, arm or leg problems following surgery, injury or fracture?              |
| <input type="checkbox"/> have a family history of heart attacks or strokes   | <input type="checkbox"/> Recurring migraine headaches or take medications to prevent them?                                  | <input type="checkbox"/> High blood pressure or take medication to control blood pressure?             |
| <input type="checkbox"/> are currently receiving medical care  | <input type="checkbox"/> Blackouts or fainting (full/partial loss of consciousness)?  | <input type="checkbox"/> Heart disease?  |
| <input type="checkbox"/> high blood pressure   | <input type="checkbox"/> Frequent or severe suffering from motion sickness (seasick, carsick, etc.)?                        | <input type="checkbox"/> Heart attack?   |
| <input type="checkbox"/> diabetes mellitus, even if controlled by diet alone   | <input type="checkbox"/> Dysentery or dehydration requiring medical intervention?   | <input type="checkbox"/> Angina, heart surgery or blood vessel surgery?                                |
|  | <input type="checkbox"/> Any dive accidents or decompression sickness?  | <input type="checkbox"/> Sinus surgery?  |
|  | <input type="checkbox"/> Inability to perform moderate exercise (example: walk 1.6 km/one mile within 12 mins.)?            | <input type="checkbox"/> Ear disease or surgery, hearing loss or problems with balance?                |
|  |   | <input type="checkbox"/> Recurrent ear problems?   |
|  |   | <input type="checkbox"/> Bleeding or other blood disorders?  |
|  |   | <input type="checkbox"/> Hernia?   |
|  |   | <input type="checkbox"/> Ulcers or ulcer surgery?  |
|  |   | <input type="checkbox"/> A colostomy or ileostomy?   |
|  |   | <input type="checkbox"/> Recreational drug use or treatment for, or alcoholism in the past five years? |

### 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?

**The information I have provided about my medical history is accurate to the best of my knowledge. I agree to accept responsibility for omissions regarding my failure to disclose any existing or past health condition.**

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

SIGNATURES OF PARENTS OR GUARDIANS WHERE APPLICABLE \_\_\_\_\_

DATE \_\_\_\_\_

Form must be filled out by student with a printed "yes" or "no" next to each question. This document must be signed by both student and parent if student is under the age of 18. If any questions are answered "yes" on page 1 of the Medical Statement, the medical form must be signed by a physician on page 2.

A physician's signature is required on page 2 if any question is answered "yes" on page 1 of the Medical History Form.

## 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 ( ) \_\_\_\_\_