



Medical declaration for entry-level certificate divers

Participant details

Name Birth date Age

MailingAddress

City State/Province/Region

Country Zip/Postalcode

Homephone Mobilephone

Email

Height Weight BMI*

Waist circumference (in cm, measured around belly button

* BMI = weight / (height x height)

Please read carefully before signing

This is a declaration in which you are informed of some potential risks involved in scuba diving and of the conduct required of you during the entry-level recreational diving certificate training program. Your signature on this statement is required for you to participate in the training.

Read this statement prior to signing it. You must complete this declaration, which includes the medical questionnaire section, to enrol in the training. If you are a minor, you must have this declaration signed by a parent or guardian.

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 have an appropriate level of physical fitness and not be extremely overweight. 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.

You will learn from the instructor the important safety rules regarding breathing and equalisation 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 declaration or the Medical Questionnaire section, review them with your instructor before signing.

Participant medical questionnaire

The purpose of this medical questionnaire is to find out if you should be examined by your doctor before participating in entry-level recreational diving certificate training. A positive response to a question does not necessarily disqualify you from diving. A positive response means that there is a pre-existing condition that may affect your safety while diving and you must seek the advice of a medical practitioner, preferably with experience in diving medicine, prior to engaging in dive activities.

	YES	NO
Could you be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Are you presently taking prescription medications? (with the exception of birth control or anti-malarial medication)	<input type="checkbox"/>	<input type="checkbox"/>
Are you over 45 years of age?	<input type="checkbox"/>	<input type="checkbox"/>
Is your BMI over 30 AND your waist circumference greater than 102 cm for males and 88 cm for females?	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had or do you currently have:

Asthma, or wheezing with breathing, or wheezing with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or severe attacks of hay fever or allergy?	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds, sinusitis or bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>
Any form of lung disease?	<input type="checkbox"/>	<input type="checkbox"/>
Pneumothorax (collapsed lung)?	<input type="checkbox"/>	<input type="checkbox"/>
Other chest disease or chest surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Behavioural health, mental or psychological problems (Panic attack, fear of closed or open spaces)?	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy, seizures, convulsions or take medications to prevent them?	<input type="checkbox"/>	<input type="checkbox"/>
Recurring complicated migraine headaches or take medications to prevent them?	<input type="checkbox"/>	<input type="checkbox"/>
Blackouts or fainting (full/partial loss of consciousness)?	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or severe suffering from motion sickness (seasick, carsick, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
Dysentery or dehydration requiring medical intervention?	<input type="checkbox"/>	<input type="checkbox"/>
Any dive accidents or decompression sickness?	<input type="checkbox"/>	<input type="checkbox"/>
Inability to perform moderate exercise (example: walk 1.6 km/one mile within 12 mins.)?	<input type="checkbox"/>	<input type="checkbox"/>
Head injury with loss of consciousness in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent back problems?	<input type="checkbox"/>	<input type="checkbox"/>
Back or spinal surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Back, arm or leg problems following surgery, injury or fracture?	<input type="checkbox"/>	<input type="checkbox"/>

High blood pressure or take medicine to control blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease?	<input type="checkbox"/>	<input type="checkbox"/>
Angina, heart surgery or blood vessel surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack?	<input type="checkbox"/>	<input type="checkbox"/>
Sinus surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Ear disease or surgery, hearing loss or problems with balance?	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent ear problems?	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding or other blood disorders?	<input type="checkbox"/>	<input type="checkbox"/>
Hernia?	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers or ulcer surgery?	<input type="checkbox"/>	<input type="checkbox"/>
A colostomy or ileostomy?	<input type="checkbox"/>	<input type="checkbox"/>
Recreational drug use or treatment for, or alcoholism in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>

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 of participant Date

Name of Parent or Guardian (if applicable) Signature Relationship Date

Training providers details

This section is to be completed and signed by the training provider.

Business name of training provider _____

Address _____

City _____ State _____ Post Code _____

Phone _____ Email _____

Has the participant answered **YES** or left blank any of the participant medical questions?

If **YES** then the participant requires a dive medical certificate certifying that the person is medically fit to dive.

Name Signature Position Date