



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/water rescue and of the conduct required of you during the scuba/water rescue training program. Your signature on this statement is required for you to participate in the scuba/water rescue training programs offered by _____ and _____ located in the city of _____, state of _____.

Read this statement prior to signing it. You must complete this Medical Statement, which includes the medical questionnaire section, to enroll in the scuba/water rescue training program. If you are a minor, you must have this Statement signed by a parent or guardian.

Diving/water rescue is an exciting and demanding activity. When performed correctly, applying correct techniques, can be relatively safe. When established safety procedures are not followed, however, there are increased risks.

To scuba dive or participate in swift water activities safely, you should not be extremely overweight or out of condition. Diving and swimming 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. If you have asthma, heart disease, other chronic medical conditions or you are taking medications on a regular basis, you should consult your doctor and the instructor before participating in this program, and on a regular basis thereafter upon completion. You will also learn from the instructor the important safety rules regarding breathing and equalization while scuba diving and swimming. Improper use of scuba/rescue 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 Questionnaire section, review them with your instructor before signing.

Medical Questionnaire:

ALLERGIES (please list ALL known allergies): _____

To the Participant:

The purpose of this Medical Questionnaire is to find out if you should be examined by your doctor before participating in diver/water rescue training. A positive response to a question does not necessarily disqualify you from diving/water rescue training. A positive response means that there is a preexisting condition that may affect your safety while diving/participating in swift water training and you must seek the advice of your physician prior to engaging in dive/water rescue activities.

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 may request that you consult with a physician prior to participating in diving/water rescue training. Your instructor will supply you with an RSTC Medical Statement and Guidelines for Physical Examination to take to your physician.

- _____ Could you be pregnant, or are you attempting to become pregnant?
- _____ Are you presently taking prescription medications? (with the exception of birth control or anti-malarial medications)
- _____ Are you over 45 years of age and can answer YES to one or more of the following?
 - Currently smoke a pipe, cigars or cigarettes
 - Have a high cholesterol level
 - Have a family history of heart attack or stroke
 - Are currently receiving medical care
 - Have high blood pressure
 - Have diabetes mellitus, even if controlled by diet alone

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)?

- _____ Other chest disease or chest surgery?
- _____ Behavioral health, mental or psychological problems (panic attack, fear of closed or open spaces)?
- _____ Epilepsy, seizures, convulsions or take medications to prevent them?
- _____ Recurring complicated migraine headaches or take medications to prevent them?
- _____ Blackouts or fainting (full/partial loss of consciousness)?
- _____ Frequent or severe suffering from motion sickness (seasick, carsick, etc)?
- _____ Dysentery or dehydration requiring medical intervention?
- _____ Any dive accidents or decompression sickness?
- _____ Inability to perform moderate exercise (ex: walk one mile within 12 mins.)?
- _____ Head injury with loss of consciousness in the past five years?
- _____ Recurrent back problems?
- _____ Back or spinal surgery?
- _____ Diabetes?
- _____ Back, arm or leg problems following surgery, injury or fracture?
- _____ High blood pressure or take medicine to control blood pressure?
- _____ Heart disease?
- _____ Heart attack?
- _____ Angina, heart surgery or blood vessel surgery?
- _____ Sinus surgery?
- _____ Ear disease or surgery, hearing loss or problems with balance?
- _____ Recurrent ear problems?
- _____ Bleeding or other blood disorders?
- _____ Hernia?
- _____ Ulcers or ulcer surgery?
- _____ A colostomy or ileostomy?
- _____ Recreational drug use or treatment for, or alcoholism in the past five years?

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

Signature of Parent/Guardian

Date