Medical Screening Statement

The purpose of this medical information sheet is to inform you whether a physician should examine you before participating in recreational scuba diving training and activities. If any of these conditions apply to you this does not necessarily disqualify you from recreational diving, but, for your own safety you must consult a physician prior to participating in recreational scuba diving activities. If in doubt, you must seek the advice of a physician. Please fill in 'YES' if the statement has applied and/or applies to you or 'NO' if the statement has never and/or does not apply to you.

Please tick Yes or No

Are you?	**YES**	**NO**
Pregnant or you suspect you may be pregnant	☐	☐
Regularly take medication (with the exception of birth control)	☐	☐
Over 45 years of age and you smoke	☐	☐
Over 45 years of age and you have a high cholesterol level	☐	☐

Did you ever have?	**YES**	**NO**
Asthma, or wheezing with breathing, or wheezing with exercise	☐	☐
Any form of lung disease	☐	☐
Pneumathomx (collapsed lur	☐	☐
History of chest surgery	☐	☐
Claustrophobia or agoraph (fear of closed or open spa	☐	☐
Epilepsy seizures, convulsions take medications to prevent them	☐	☐
History of head injury or blackouts or fainting (full/partial loss of consciousness)	☐	☐
History of serious disability/injury	☐	☐
History of diving accidents or decompression sickness	☐	☐
History of diabetes	☐	☐
History of high blood pressure or take medication to control blood pressure	☐	☐
History of any heart disease	☐	☐
History of ear disease, hearing loss or problems with balance	☐	☐
History of thrombosis or blood clotting	☐	☐
Psychiatric diseases	☐	☐

Customer Declarations

I am aware that I could be unfit to dive if I currently have or develop any of the following conditions	**INITIALS**
Cold sinusitis, or any breathing problems (e.g. bronchitis, hay fever)	
Acute migraine or headache	
Any kind of surgery within the last six weeks	
Under influence of alcohol, drugs or medications effecting the ability t	
Fe dizziness, naus v ing and diarrhoe	
oblems equalisin pping ears)	
Ac ulcers	
Pregnancy or suspected pregnancy	

I Confirm that the answers to the statements in this Medical Screening Statement are accurate to the best of my knowledge.

I accept full responsibility for failing to disclose any past or existing medical condition.

I accept full responsibility to retake this Screening should my medical status change or should I become unsure of the statement given during the course of my scuba diving activities.

The declaration is otherwise valid for one year from date of signature

Physician's Statement

In my opinion, the applicant is fit to take part in recreational scuba diving activities.

Signature of Physician

Date

Full Name

Address

Customer Name

Signature

Date of Birth

Parental/guardian Name (where applicable)

Signature

Date

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