

Student Record Folder

Name	
Address	Y P
City	ľ
State/Province	Zip/Postal Code
Email	
Other Social Media Contact (optional)	
Telephone: Day	Evening
Gender: Female Male	Date of Birth
eLearning Username	
EMERGENCY CONTACT	
Name	
Telephone: Day	Evening
Email	
Relationship	

COURSE	C.	\mathbf{H}	EC	CK	\mathbb{L}	[S]	Γ	
	Scuba	Nitrox	Advanced	Rescue	First Aid	Master	Specialty	Technical
Course Name	-							
Course Tuition Paid								
Application								
Waiver								
Medical								
eLearning								
Classroom								
Confined Water								
Open Water								
Written Exam								
Temp Card Issued								
c-Card Issued								
Gear Assigned								
Gear Returned								











Diver Medical | Participant Questionnaire

Recreational scuba diving and freediving requires good physical and mental health. There are a few medical conditions which can be hazardous while diving, listed below. Those who have, or are predisposed to, any of these conditions, should be evaluated by a physician. This Diver Medical Participant Questionnaire provides a basis to determine if you should seek out that evaluation. If you have any concerns about your diving fitness not represented on this form, consult with your physician before diving. If you are feeling ill, avoid diving. If you think you may have a contagious disease, protect yourself and others by not participating in dive training and/or dive activities. References to "diving" on this form encompass both recreational scuba diving and freediving. This form is principally designed as an initial medical screen for new divers, but is also appropriate for divers taking continuing education. For your safety, and that of others who may dive with you, answer all questions honestly.

Directions

Complete this questionnaire as a prerequisite to a recreational scuba diving or freediving course.

Note to women: If you are pregnant, or attempting to become pregnant, do not dive.

1	I have had problems with my lungs, breathing, heart and/or blood affecting my normal physical or mental performance.	Yes □ Go to box A	No 🗆
2	I am over 45 years of age.	Yes □ Go to box B	No 🗆
3	I struggle to perform moderate exercise (for example, walk 1.6 kilometer/one mile in 14 minutes or swim 200 meters/yards without resting), OR I have been unable to participate in a normal physical activity due to fitness or health reasons within the past 12 months.	Yes □*	No 🗆
4	I have had problems with my eyes, ears, or nasal passages/sinuses.	Yes □ Go to box C	No □
5	I have had surgery within the last 12 months, OR I have ongoing problems related to past surgery.	Yes □*	No □
6	I have lost consciousness, had migraine headaches, seizures, stroke, significant head injury, or suffer from persistent neurologic injury or disease.	Yes □ Go to box D	No 🗆
7	I am currently undergoing treatment (or have required treatment within the last five years) for psychological problems, personality disorder, panic attacks, or an addiction to drugs or alcohol; or, I have been diagnosed with a learning or developmental disability.	Yes □ Go to box E	No 🗆
8	I have had back problems, hernia, ulcers, or diabetes.	Yes □ Go to box F	No □
9	I have had stomach or intestine problems, including recent diarrhea.	Yes □ Go to box G	No □
10	I am taking prescription medications (with the exception of birth control or or anti-malarial drugs other than mefloquine (Lariam).	Yes □*	No 🗆

Participant Signature If you answered NO to all 10 questions above, a medical evaluation is not required. Please read and agree to the participant statement below by signing and dating it. Participant Statement: I have answered all questions honestly, and understand that I accept responsibility for any consequences resulting from any questions I may have answered inaccurately or for my failure to disclose any existing or past health conditions. Participant Signature (or, if a minor, participant's parent/guardian signature required. Date (dd/mm/yyyy) Participant Name (Print) Birthdate (dd/mm/yyyy)

* If you answered YES to questions 3, 5 or 10 above OR to any of the questions on page 2, please read and agree to the statement above by signing and dating it AND take all three pages of this form (Participant Questionnaire and the Physician's Evaluation Form) to your physician for a medical evaluation. Participation in a diving course requires your physician's approval.

Participant Name Birthdate

(Print) Date (dd/mm/yyyy)

Diver Medical | Participant Questionnaire Continued

BOX A – I HAVE/HAVE HAD:		
Chest surgery, heart surgery, heart valve surgery, an implantable medical device (eg, stent, pacemaker, neurostimulator), pneumothorax, and/or chronic lung disease.	Yes □*	No □
Asthma, wheezing, severe allergies, hay fever or congested airways within the last 12 months that limits my physical activity/exercise.	Yes □*	No □
A problem or illness involving my heart such as: angina, chest pain on exertion, heart failure, immersion pulmonary edema, heart attack or stroke, OR am taking medication for any heart condition.	Yes □*	No □
Recurrent bronchitis and currently coughing within the past 12 months, OR have been diagnosed with emphysema.	Yes □*	No □
Symptoms affecting my lungs, breathing, heart and/or blood in the last 30 days that impair my physical or mental performance.	Yes □*	No □
BOX B - I AM OVER 45 YEARS OF AGE AND:		
I currently smoke or inhale nicotine by other means.	Yes □*	No E
I have a high cholesterol level.	Yes □*	No E
I have high blood pressure.	Yes □*	No E
I have had a close blood relative die suddenly or of cardiac disease or stroke before the age of 50, OR have a family history of heart disease before age 50 (including abnormal heart rhythms, coronary artery disease or cardiomyopathy).	Yes □*	No E
BOX C – I HAVE/HAVE HAD:		
Sinus surgery within the last 6 months.	Yes □*	No E
Ear disease or ear surgery, hearing loss, or problems with balance.	Yes □*	No E
Recurrent sinusitis within the past 12 months.	Yes □*	No [
Eye surgery within the past 3 months.	Yes □*	No [
BOX D – I HAVE/HAVE HAD:		
Head injury with loss of consciousness within the past 5 years.	Yes □*	No [
Persistent neurologic injury or disease.	Yes □*	No [
Recurring migraine headaches within the past 12 months, or take medications to prevent them.	Yes □*	No [
Blackouts or fainting (full/partial loss of consciousness) within the last 5 years.	Yes □*	No [
Epilepsy, seizures, or convulsions, OR take medications to prevent them.	Yes □*	No [
BOX E – I HAVE/HAVE HAD:		
Behavioral health, mental or psychological problems requiring medical/psychiatric treatment.	Yes □*	No E
Major depression, suicidal ideation, panic attacks, uncontrolled bipolar disorder requiring medication/psychiatric treatment.	Yes □*	No E
Been diagnosed with a mental health condition or a learning/developmental disorder that requires ongoing care or special accommodation.	Yes □*	No E
An addiction to drugs or alcohol requiring treatment within the last 5 years.	Yes □*	No E
BOX F – I HAVE/HAVE HAD:		
Recurrent back problems in the last 6 months that limit my everyday activity.	Yes □*	No E
Back or spinal surgery within the last 12 months.	Yes □*	No E
Diabetes, either drug or diet controlled, OR gestational diabetes within the last 12 months.	Yes □*	No E
An uncorrected hernia that limits my physical abilities.	Yes □*	No E
Active or untreated ulcers, problem wounds, or ulcer surgery within the last 6 months.	Yes □*	No E
BOX G – I HAVE HAD:		
Ostomy surgery and do not have medical clearance to swim or engage in physical activity.	Yes □*	No E
Dehydration requiring medical intervention within the last 7 days.	Yes □*	No [
Active or untreated stomach or intestinal ulcers or ulcer surgery within the last 6 months.	Yes □*	No [
Frequent heartburn, regurgitation, or gastroesophageal reflux disease (GERD).	Yes □*	No [
Active or uncontrolled ulcerative colitis or Crohn's disease.	Yes □*	No [
Bariatric surgery within the last 12 months.	Yes □*	No [

*Physician's medical evaluation required (see page 1).

Diver Medical | Medical Examiner's Evaluation Form

Participant Name

	(Print)	Date (dd/mm/yyyy)
	uests your opinion of his/her medical suitability to partici uhms.org for medical guidance on medical conditions your evaluation.	
Evaluation Resul	t	
Approved – I find no cond	litions that I consider incompatible with recreational scuba	a diving or freediving.
Not approved – I find con	ditions that I consider incompatible with recreational scu	ba diving or freediving.
Signature of certified medi	ical doctor or other legally certified medical provider	Date (dd/mm/yyyy)
Medical Examiner's Name		
	(Print)	
Clinical Degrees/Credentials	•	
Clinic/Hospital		
Address		
Phone	Email	
	Physician/Clinic Stamp (optional)	
	Created by the <u>Diver Medical Screen Committee</u> in asso	ociation with the
	following bodies: The Undersea & Hyperbaric Medical Society	Solution with the
	DAN (US)	

Birthdate

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Hyperbaric Medicine Division, University of California, San Diego

DAN Europe

RELEASE OF LIABILITY, WAIVER OF CLAIMS, AND EXPRESS ASSUMPTION OF RISK AGREEMENT



PLEASE READ AND BE CERTAIN YOU UNDERSTAND THE IMPLICATIONS OF SIGNING THIS RELEASE

EXPRESS ASSUMPTION OF RISK ASSOCIATED WITH SNORKELING, APNEA DIVING, SCUBA DIVING, FIRST AID, AND RELATED ACTIVITIES

that I have been fully informed of the inherent hazards and risks associated with Snorkeling, Apnea Diving, SCUBA Diving, First Aid, and instruction related thereto ("Diving Activities"). I fully understand that these hazards and risks can lead to severe injury and even loss of life. I understand that Snorkeling, Apnea Diving, SCUBA Diving, and First Aid activities may be conducted at a site that is remote from a recompression chamber and competent medical assistance. Nevertheless, I choose to proceed even in the absence of a recompression chamber and competent medical assistance. Additionally, I understand that there are also hazards and risks associated with Snorkeling, Apnea Diving, SCUBA Diving, First Aid, and related travel, including, but not limited to the possible injury or loss of life as a result of a vessel accident, being hit by a vessel while in or under the water, while boarding, disembarking, exiting and/or reboarding the vessel to begin or end diving activities, equipment failure, user error, as well as during travel to and from dive sites. Despite the potential hazards and risks associated with Snorkeling, Apnea Diving SCUBA Diving, First Aid activities, and related activities which can include but are not limited to, aquatic life encounters, currents, waves, barotraumas (pressure change related injuries), sudden loss of visibility, entrapment underwater in wrecks, caves, vegetation, fishing line, fishing nets or debris, I wish to proceed and I freely accept and expressly assume all hazards and risks, that may arise from Snorkeling, Apnea Diving, SCUBA Diving, First Aid activities, and related activities which could result in personal injury, loss of life and property damage to me.

RELEASE OF LIABILITY AND WAIVER OF CLAIMS AGREEMENT:

In consideration of being allowed to participate in Snorkeling, Apnea Diving, SCUBA Diving, and First Aid activities as well as the use of any of the facilities and the use of the equipment of the below listed persons or entities, I hereby agree as follows:

1. TO WAIVE AND RELEASE ANY AND ALL CLAIMS based upon negligence, active or passive with the exception of intentional, wanton or willful misconduct that I may have in the future against any of the following named persons or entities (hereinafter referred to as Releasees); National Association of Underwater Instructors, Inc. (NAUI) and subsidiary companies:

,,,	
(Instructor/s and Leader/s)	
(Facility/ies)	
(Others)	

- 2. To release the Releasees, their officers, directors, employees, representatives, agents and volunteers, from liability and responsibility, whatsoever, for any claims or causes of action that I, my estate, heirs, executors or assigns may have for personal injury, property damage or wrongful death arising from Snorkeling, Apnea Diving, SCUBA Diving, First Aid activities, and related activities whether caused by active or passive negligence of the Releasees or otherwise with the exception of gross negligence. By executing this Agreement, I agree to hold the Releasees harmless for any injury or loss of life which may occur to me during Snorkeling, Apnea Diving, SCUBA Diving, and First Aid activities and/or instruction, and any and all future courses of instruction, programs and Snorkeling, Apnea Diving, SCUBA Diving, and First Aid related travel I undertake.
- 3. I fully understand that Snorkeling, Apnea Diving, SCUBA Diving, and First Aid related activities are physically strenuous and I will be exerting myself during this course of instruction. I understand and agree that if I am injured or killed as a result of heart attack, panic, hyperventilation, oxygen toxicity, hypoxia, narcosis, aquatic life encounters, drowning or any other cause, that I expressly assume the risk of these injuries and/or attended death and that I will not hold the Releasees included in this Agreement responsible in any other way.
- 4. By entering into this Agreement, I am not relying on any oral or written representation or statements made by the Releasees, other than what is set forth in this Agreement. I further agree that this Agreement shall be governed by and interpreted in accordance with the laws of the State of Florida, United States of America.
- 5. If any provision, section, subsection, clause or phrase of this Agreement is found to be unenforceable or invalid, that portion shall be severed from this Agreement. The remainder of this Agreement will then be construed as though the unenforceable portion had never been contained in the Agreement. The English language version of this document shall be controlling in all respects and shall prevail in case of any inconsistencies with translated versions.

I fully understand that the terms of this Agreement are contractual in nature and not a mere recital. I further state by way of my signature I have signed this Agreement of my own free act. I hereby declare that I am of legal age and am competent to sign this Agreement or, if not, that my parent or legal guardian shall sign on my behalf, and that my parent or legal guardian is in complete understanding and concurrence with this Agreement.

INSTRUCTOR/LEADER CONFIRMATION I HAVE REVIEWED THIS AGREEMENT AND CONFIRM THAT IT HAS BEEN PROPERLY COMPLETED.

Signature of Instructor/Leader:______ Date: _____

Revised: June 2023