



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, blood	Yes <input type="checkbox"/> Go to Box A	No <input type="checkbox"/>
2. I am over 45 years of age.	Yes <input type="checkbox"/> Go to Box B	No <input type="checkbox"/>
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 <input type="checkbox"/> *	No <input type="checkbox"/>
4. I have had problems with my eyes, ears, or nasal passages/sinuses.	Yes <input type="checkbox"/> Go to Box C	No <input type="checkbox"/>
5. I have had surgery within the last 12 months, OR I have ongoing problems related to past surgery.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
6. I have lost consciousness, had migraine headaches, seizures, stroke, significant head injury, or suffer from persistent neurologic injury or disease.	Yes <input type="checkbox"/> Go to Box D	No <input type="checkbox"/>
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 disability.	Yes <input type="checkbox"/> Go to Box E	No <input type="checkbox"/>
8. I have had back problems, hernia, ulcers, or diabetes.	Yes <input type="checkbox"/> Go to Box F	No <input type="checkbox"/>
9. I have had stomach or intestine problems, including recent diarrhea.	Yes <input type="checkbox"/> Go to Box G	No <input type="checkbox"/>
10. I am taking prescription medications (with the exception of birth control or anti-malarial drugs other than mefloquine/Lariam).	Yes <input type="checkbox"/> *	No <input type="checkbox"/>

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)
_____	_____
Instructor Name (Print)	Facility Name (Print)

* 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 _____ (Print) Birthdate _____ Date (dd/mm/yyyy)

Diver Medical | Participant Questionnaire Continued

Box A – I have/have had:

Chest surgery, heart surgery, heart valve surgery, stent placement, or a pneumothorax (collapsed lung).	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Asthma, wheezing, severe allergies, hay fever or congested airways within the last 12 months that limits my physical activity/exercise.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
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 <input type="checkbox"/> *	No <input type="checkbox"/>
Recurrent bronchitis and currently coughing within the past 12 months, OR have been diagnosed with emphysema.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
A diagnosis of COVID-19.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>

Box B – I am over 45 years of age AND:

I currently smoke or inhale nicotine by other means.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
I have a high cholesterol level.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
I have high blood pressure.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
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 <input type="checkbox"/> *	No <input type="checkbox"/>

Box C – I have/have had:

Sinus surgery within the last 6 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Ear disease or ear surgery, hearing loss, or problems with balance.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Recurrent sinusitis within the past 12 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Eye surgery within the past 3 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>

Box D – I have/have had:

Head injury with loss of consciousness within the past 5 years.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Persistent neurologic injury or disease.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Recurring migraine headaches within the past 12 months, or take medications to prevent them.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Blackouts or fainting (full/partial loss of consciousness) within the last 5 years.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Epilepsy, seizures, or convulsions, OR take medications to prevent them.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>

Box E – I have/have had:

Behavioral health, mental or psychological problems requiring medical/psychiatric treatment.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Major depression, suicidal ideation, panic attacks, uncontrolled bipolar disorder requiring medication/psychiatric treatment.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Been diagnosed with a mental health condition or a learning/developmental disorder that requires ongoing care.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
An addiction to drugs or alcohol requiring treatment within the last 5 years.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>

Box F – I have/have had:

Recurrent back problems in the last 6 months that limit my everyday activity.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Back or spinal surgery within the last 12 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Diabetes, drug- or diet-controlled, OR gestational diabetes within the last 12 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
An uncorrected hernia that limits my physical abilities.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Active or untreated ulcers, problem wounds, or ulcer surgery within the last 6 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>

Box G – I have had:

Ostomy surgery and do not have medical clearance to swim or engage in physical activity.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Dehydration requiring medical intervention within the last 7 days.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Active or untreated stomach or intestinal ulcers or ulcer surgery within the last 6 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Frequent heartburn, regurgitation, or gastroesophageal reflux disease (GERD).	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Active or uncontrolled ulcerative colitis or Crohn's disease.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Bariatric surgery within the last 12 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>

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

EXPERIENCE SCUBA DIVE

STATEMENT OF UNDERSTANDING AND ASSUMPTION OF RISK AGREEMENT - INTRODUCTORY SCUBA DIVING

I, _____ hereby affirm that I am aware that skin and scuba diving have inherent risks which may result in serious injury or death. In particular, I acknowledge:

1. That I have read and understand the safe diving practices. and have had any questions answered to my satisfaction. I recognise that these practices are for my own safety and well being, and that failure to adhere to them can place me in jeopardy when diving.
2. That diving with compressed air involves certain inherent risks of decompression illness, embolism, and other hyperbaric injuries and that such injuries may result in death or serious disablement.
3. That injuries of the type referred to in Clause 2 may require treatment in a recompression chamber. That the open water dives that are part of the Introductory Scuba Diving program may be conducted at a site that is remote either by time and/ or distance from a recompression chamber. I choose to participate in the Introductory Scuba Diving program despite the possible absence of a recompression chamber in proximity to the dive site.
4. That skin diving and scuba diving are physically demanding activities and in susceptible individuals may cause heart attack, panic or hyperventilation
5. That scuba diving involves the use of equipment that may malfunction giving rise to risk of death or disablement.
6. That skin diving and scuba diving necessarily involve the exposure to the natural elements including but not limited to storm, tempest, wind, tides and marine life. Such exposure brings with it attendant risk of death or disablement.
7. That the Introductory Scuba Diving program is designed to provide me with a safe introduction to scuba diving. The program is not intended to train me as a competent diver. I further understand and agree that I must be thoroughly instructed in the use of SCUBA under the direct supervision of a qualified instructor to become a certified, competent diver.
8. In consideration of being allowed to participate in this Introductory Scuba Diving program, I hereby personally assume all risks in connection with the said program, for any harm, injury or damage that may befall me while I am participating in this Introductory Scuba Diving program, including all risks connected therewith, whether foreseen or unforeseen,
9. The information I have provided about my medical history on the Medical Declaration is accurate to the best of my knowledge and belief. I agree to accept the responsibility for omissions regarding my failure to disclose any existing or past health conditions.
10. I further state that I am of lawful age and legally competent to sign this statement of understanding, or alternatively, the written consent of my parent or legal guardian is provided herewith.
11. In the event that any part of this document is held to be inconsistent with any relevant statute, then the parties agree that the document will be invalid to the extent of that inconsistency only.
12. I understand that the terms herein are contractual and not a mere recital, and that I have signed this document of my own free will.

Participant Signature

Parent / Guardian Signature

Date

LIABILITY RELEASE AND STATEMENT OF INTENTION - INTRODUCTORY SCUBA DIVING

I, the aforementioned, have fully informed myself of the contents of the "Statement of Understanding and Assumption of Risk Agreement" and this "Liability Release" before signing it on behalf of myself and my heirs. I further agree that neither the dive professional conducting this activity, _____, the facility through which this activity is conducted, **Experience Scuba**, nor any of their employees, officers, agents or assigns (hereinafter referred to as the "Released Parties") may be held liable or responsible in any way for any injury, death, or other damages to me or my family, heirs or assigns that may occur as a result of my participation in this Introductory Scuba Diving program, whether such injury or damage is foreseen or unforeseen.

I, THE AFOREMENTIONED, BY THIS INSTRUMENT DO EXEMPT AND RELEASE THE RELEASED PARTIES FROM ALL LIABILITY AND RESPONSIBILITY WHATSOEVER FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH HOWSOEVER CAUSED, INCLUDING BUT NOT LIMITED TO ANY NEGLIGENT ACT OR OMISSION OF THE RELEASED PARTIES, WHETHER PASSIVE OR ACTIVE.

Participant Signature

Parent / Guardian Signature

Date

EXPERIENCE SCUBA DIVE

PART B

First Name

Last Name

Hotel Name & Room Number

Date of Birth (DD/MM/YYYY)

Email

Mobile Number

Emergency Contact Number

Emergency Contact Relation

DATA PRIVACY

I consent to the collection of the personal data in this form by **Experience Scuba Dive** running the dive program in which I intend to participate and to its use to satisfy regulatory requirements, insurance requirements and for quality control purposes.

I acknowledge and understand that the information provided by me in the diver medical form will be retained by **Experience Scuba Dive** in accordance with its own privacy policy but may be provided to its insurers or associated entities if required for safety, legal or review reasons.

Participant Signature

Parent / Guardian Signature

Date

SAFE DIVING PRACTICES

These practices have been compiled for your review and acknowledgment and are intended to increase your comfort and safety in diving.

- I understand that upon completing the Introductory Scuba Diving program, I will not be qualified to dive independently without certified professional guiding me.
- To equalise my ears and sinus air spaces, I will need to blow gently against pinched nostrils every few feet/one metre while descending.
- If I have discomfort in my ears or sinuses during descent, I should stop my descent and alert my instructor. Underwater, I should breathe slowly, deeply, continuously and never hold my breath.
- I should respect underwater life and not touch, tease or harass an underwater organism since it may harm me and/or I may harm it.

FLYING AFTER DIVING RECOMMENDATIONS:

1. For single dives within no decompression limits, a minimum pre-flight surface interval of 12 hours is suggested.
2. For repetitive dives and/or multi-day dives within the no decompression limits, a minimum pre-flight surface interval of hours is suggested.
3. For dives requiring decompression stops, a minimum pre-flight surface interval greater than 18 hours is suggested.