It's Pure Diving… Made Easy

To The Participant:

You must complete this Medical Statement, which includes the Medical-history information section, prior to enjoying any recreational scuba diving services.

Its purpose is to inform you whether you should be examined by a physician before participating in recreational diving training. If any of these conditions apply to you, this does not necessarily disqualify you. It only means that for your own safety, you must seek the advice of a physician prior to participating in Recreational Scuba Diving/Training.

Please acknowledge that you have read and understood the information provided below by initialling each individual point.

1. YOU MUST CONSULT A PHYSICIAN IF:	YES	NO	INITIALS
You are pregnant or you suspect you may be pregnant			
You regularly take medications (with the exception of birth control)			
You are over 45 years of age and one or more of the following apply:-	YES	NO	INITIALS
You Smoke			
You have a High Cholesterol Level			

2. YOU MUST CONSULT A PHYSICIAN IF YOU EVER HAD:	YES	NO	INITIALS
Asthma, or wheezing with breathing, or wheezing with exercise			
Any Form of Lung Disease			
Pneumothorax (Collapsed Lung)			
History of Chest Surgery			
Claustrophobia or Agoraphobia (fear of closed or open spaces)			
Epilepsy, Seizures, Convulsions or take medications to prevent them			
History of Blackouts or fainting (full/partial loss of consciousness)			
History of Diving Accidents or Decompression Sickness			
History of Diabetes			
History of High Blood Pressure or take medications to control blood pressure			
History of Heart Disease			
History of Ear Disease, Hearing Loss or Problems with balance			
History of Thrombosis or Blood Clotting			
Psychiatric Diseases			

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3. I AM AWARE THAT I COULD BE UNFIT TO DIVE IF I 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 (6) weeks	
Under Influence of Alcohol, Drugs or Medications Effecting the ability to react	
Fever, Dizziness, Nausea, Vomiting and Diarrhoea	
Problems Equalising (Popping Ears)	
Acute Gastric Ulcers	
Pregnancy	

Name: ____

Address: ____

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Date of Birth: ____________________

I, confirm that the answers to the questions above are true and complete.

Signature: ______________________________ Date: ____________________

Parental/Guardian consent when participant is a minor.

Name of Parent/Guardian * __________________________* *delete as applicable*

Address: ____

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Signature: ______________________________ Date: ____________________

This declaration is valid for one year from date of signature