SNORKELING, INTRODUCTORY DIVE, DIVE COURSE
PARTICIPANT INFORMATION & MEDICAL FORM

(Confidential Information - 4 pages))

Personal Details (please print)

Name_________________________________ Date of birth____________

Age____________ Weight________________ Height___________________

Address____

City__________________ Postal Code_________ Country______________

Home telephone____________________ Work telephone_________________

Fax/e-mail____

Name of doctor___________________________ Telephone______________

Last medical examination:

Date__________ Name of doctor _______________ Telephone____________

Type of activity: Swimming (snorkeling) with dolphins______
Introductory dive ________ Guided dive________

In order to participate in this program, you are required to read this statement, complete and sign this form and have a physician fill out and sign the section on the reverse side.

Before you become involved in scuba diving/snorkeling activities, it is important that you are aware of some of the potential risks. Diving/snorkeling is an exciting and demanding activity. When performed correctly, applying correct techniques, it is very safe. When, however, established safety procedures are not followed, there are dangers.

To scuba dive/snorkel safely, you should try to maintain good health. Avoid being excessively overweight, and avoid being in poor physical condition. All your body air spaces must be effective and healthy. A person who suffers from any severe medical problem, is in ill health, or does not feel well should not dive. If you are taking medication, consult with your doctor and your instructor before participation in any program.

GENERAL INFORMATION

Are you a swimmer?_________
How long have you been swimming?____________________________________
How well?____
Previous snorkeling/diving experience: Since?____________
Where?______________ How often?____________________

MEDICAL HISTORY

Please answer the following questions regarding your past or present medical history with a YES or NO.

1. ___Could you be pregnant or are you attempting to become pregnant ?
2. ___Do you regularly take prescription or nonprescription medications?
   (with exception of birth control) Type ? _______________________
3. ___Are you over 45 years of age and have one or more of the following?

- Currently smoke a pipe, cigar or cigarettes
- Have a high cholesterol level
- Have a family history of heart attacks or strokes

Have you ever had or do you currently suffer from...

1. ___Asthma, or wheezing with breathing, or wheezing with exercise?
2. ___Frequent or severe attacks of hay fever?
3. ___Frequent colds, sinusitis or bronchitis?
4. ___Any form of lung disease?
5. ___Pnemothorax (collapsed lung)?
6. ___History of chest surgery?
7. ___Claustrophobia or agoraphobia (fear of closed or open spaces)?
8. ___Behavioral health problems?
9. ___Epilepsy, seizures, convulsions or take medication to prevent them?
10. ___Recurring migraine headaches or take medication to prevent them?
11. ___History of blackouts or fainting (full/partial loss of consciousness)?
12. ___Motion sickness (seasick, carsick, etc.)?
13. ___Problems with your cough reflex or intercostal muscles?
14. ___History of diving accidents or decompression sickness?
15. ___History of recurrent back problems?
16. ___History of back surgery?
17. ___History of diabetes?
18. ___Any back, arm or leg problems after surgery, injury or fracture?
19. ___Inability to perform moderate exercises?
20. ___High blood pressure or take medication to control it?
21. ___History of any heart attacks?
22. ___Angina, heart surgery or blood vessel surgery?
23. ___History of heart disease?

24. ___History of ear or sinus surgery?
25. ___History of ear disease, hearing loss or problems with balance?
26. ___Any problems equalizing your ears with air or mountain travel?
27. ___History of bleeding or other disorders?
28. ___Any loss of sensory responses (feeling)?
29. ___History of any type of hernia?
30. ___History of ulcers or ulcer surgery?
31. ___History of drug or alcohol abuse?
32. ___History of colostomy?

If you are disabled through illness or injury, how long ago did it happen?

____

Please describe the cause.

____

____

Should you answer YES to any of the questions below, please give a brief explanation where necessary.

Do you...

1. use a catheter?_______ Type?__________________________________
2. have a respiratory disorder?_____ Explain:______________________
3. suffer from heat loss problems, thermoregulation?__________________
   Explain:____
4. have any loss of muscle control in the mouth or lips? ____________
   Explain:____
5. suffer from spasms? ______________________________________
6. suffer from Dysreflexia?_________ Explain:__________
7. have any speech impairment? ______________________________
8. have any hearing loss?___________________________________
9. have any other medical problems not covered: ____________________

Please provide (in your own words) the following general information:

1. Is your physical handicap a result of a brain injury?____________________
   ____
2. General description - appearance: does it suit your age/behavior?
   ____
   ____

3. Motor skills development: ____
____
____

4. Sense perception (sight, hearing, touch, eye contact): _________________
____
____

5. Level of concentration, attention span, perseverance, motivation, understanding____
____

6. Level of spoken communication (speech):___________________________
____
____

7. Independence in dressing, eating, sanitary habits, ability to follow instructions, acclimatization in immediate surroundings, sense of responsibility, relation to time:
____
____
____

The information I have given above is accurate to the best of my knowledge.

Signature of applicant:_________________________
Date:____________________

Signature of parent or guardian (if applicable)___________________________
Date:____________________

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