



MEDICAL EVALUATION AND PHYSICIAN APPROVAL FORM

Please print or type

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ PHONE _____

To the Instructor: If any condition listed on the medical history information is marked by a **Yes**, you are required to individually interview the student. If, as a result of the interview, you are unsure whether or not the condition is a contraindication to diver training send the student to a physician for a medical exam.

To the Physician: This person is an applicant for training in diving with self-contained underwater breathing apparatus (SCUBA). This is an activity which puts unusual stress on the individual in several ways. A list of contraindications is on the reverse of this form for your reference.

MEDICAL HISTORY INFORMATION

HISTORY STATEMENT: I understand that skin and scuba diving are strenuous activities involving significant pressure changes and that normal, healthy heart, lungs, ear and essential prerequisites for my safety and well-being. I hereby confirm that to the best of my knowledge my circulatory and respiratory systems and body air spaces are normal and that I have no severe emotional or neurological problems or communicable diseases. I understand that I need to seek unconditional approval for diving from a licensed physician if I am uncertain as to my physical fitness for the rigors of diving.

Write Y (Yes) or N (No) next to all of the following, and explain under NOTES, any Yes answers.

The student applicant's medical history below was provided during the enrollment process.

- | | | |
|--|--|--|
| <input type="checkbox"/> Behavioral health problems | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Contact lenses |
| <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Dental plates |
| <input type="checkbox"/> Agoraphobia | <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> Physical disability |
| <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Serious injury |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Back/spinal surgery | <input type="checkbox"/> Over 40 years old |
| <input type="checkbox"/> Ear or hearing problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Trouble equalizing pressure | <input type="checkbox"/> Ulcers | <input type="checkbox"/> HIV positive |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Colostomy | <input type="checkbox"/> Regular medication |
| <input type="checkbox"/> Severe hayfever | <input type="checkbox"/> Hernia | <input type="checkbox"/> Drug allergies |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Dizziness or fainting | <input type="checkbox"/> Alcohol or drug abuse |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Recent surgery | <input type="checkbox"/> Rejected from any activity |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Hospitalized | <input type="checkbox"/> for medical reasons |
| <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Any medical condition not listed: |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Motion Sickness | |

NOTES:

I certify that the above information is correct to the best of my knowledge.

SIGNATURE OF PARTICIPANT: _____ Date: _____

I am a minor and my parent or guardian has signed below.

SIGNATURE OF PARENT OR GUARDIAN: _____ Date: _____

Please note that the medical examination form presents a choice under IMPRESSION. We can only accept unconditional approval as stated for student applicants desiring to begin or continue training. If you conclude that diving is not in the individual's best interest or that their medical condition is likely to present a probable direct threat to others, please discuss your opinion with the person and check disapproval.

IMPRESSION:

- APPROVAL (I find no medical conditions I consider incompatible with diving.)
- DISAPPROVAL (This applicant has medical conditions which in my opinion clearly would constitute unacceptable hazards to health and safety in diving.)

Date _____ Signature _____, MD.

Physician's Name (print) _____

Address _____

Phone _____