

Medical Statement

----- PATIENT RECORD — CONFIDENTIAL INFORMATION -----

Please read carefully before signing.

This is a statement in which you and your child are informed of some potential risks involved in scuba diving and of the conduct required of the child during their participation in the program. Your (parent/guardian) signature on this statement is required for the child to participate in this program offered by:

(INSTRUCTOR) _____
 and (FACILITY) _____
 located in the city of _____
 and state of _____.

Read and discuss this statement prior to signing it. This Medical Statement must be completed, which includes the medical history section, to enroll in this child development program involving scuba. Since the child is a minor, this statement must be signed by the child's parent/guardian.

Diving is an exciting and demanding activity. When performed

correctly, applying correct techniques, it is very safe. When established safety procedures are not followed, however, there are dangers.

To scuba dive safely, the child must not be extremely overweight or out of condition. Diving can be strenuous under certain conditions. The child's respiratory and circulatory systems must be in good health. All body air spaces must be normal and healthy. A child with heart trouble, a current cold or congestion, epilepsy, asthma, a severe medical problem should not dive. If the child is taking medication, consult the child's physician and the Instructor before participation in this program. The child will also need to learn from the Instructor the important safety rules regarding breathing and equalization while scuba diving. Improper use of scuba equipment can result in serious injury. The child must be thoroughly instructed in its use under direct supervision of a qualified instructor to use it safely.

If there are any additional questions regarding this Medical Statement or the Medical History section, review them with the Instructor or consult the child's physician before signing.

Medical History

To the Participant's Parent/Guardian:

The purpose of this medical questionnaire is to find out if a physician should examine the child before participating in this program. A positive response to a question does not necessarily disqualify the child from diving. A positive response means that there is a preexisting condition that may affect the child's safety while diving and you (parent/guardian) must seek the advice of the child's physician.

Please answer the following questions on the child's past or present medical history with a YES or NO. If you (parent/guardian) are not sure, answer YES. If any of these items apply to the child, we must request that you consult with the child's physician prior to he/she participating in the program. The Instructor will supply you with a medical statement and guidelines for recreational scuba diver's physical examination to take to the child's physician.

- | | | |
|---|--|--|
| <p>___ Is the child pregnant or do you suspect the child is pregnant?
 ___ Does the child regularly take prescription or non-prescription medications?
 HAS THE CHILD EVER HAD OR DOES THE CHILD CURRENTLY HAVE...
 ___ Asthma, or wheezing with breathing, or wheezing with exercise?
 ___ Frequent or severe attacks of hayfever or allergy?
 ___ Frequent colds, sinusitis or bronchitis?
 ___ Any form of lung disease?
 ___ Pneumothorax (collapsed lung)?
 ___ History of being born premature and having to be on oxygen or needing mechanical ventilation?
 ___ History of congenital heart problems such as a heart murmur during the newborn period that should have resolved?</p> | <p>___ Claustrophobia or agoraphobia (fear of closed or open spaces)?
 ___ Behavioral health problems?
 ___ Epilepsy, seizures, convulsions or take medications to prevent them?
 ___ Recurring migraine headaches or take medications to prevent them?
 ___ History of blackouts or fainting (full/partial loss of consciousness)?
 ___ Do you frequently suffer from motion sickness (seasick, carsick, etc.)?
 ___ History of diving accidents or decompression sickness?
 ___ History of recurrent back problems?
 ___ History of back surgery?
 ___ History of diabetes?
 ___ History of back, arm or leg problems following surgery, injury or fracture?
 ___ Inability to perform moderate exercise (walk one mile within 12 minutes)?
 ___ History of high blood pressure or take medications to control blood pressure?</p> | <p>___ History of chest surgery?
 ___ History of any heart disease?
 ___ History of heart attacks?
 ___ Angina or heart blood vessel surgery?
 ___ History of ear drainage other than wax?
 ___ History of ear or sinus surgery?
 ___ PE tubes or surgery to patch an ear drum from a PE tube or perforation that did not heal?
 ___ History of ear disease, hearing loss or problems with balance?
 ___ History of problems equalizing (popping) ears with airplane or mountain travel?
 ___ History of bleeding or other blood disorders?
 ___ History of any type of hernia?
 ___ History of ulcers or ulcer surgery?
 ___ History of colostomy?
 ___ Frequent nose bleeds or history of having a nose bleed treated because it would not stop bleeding?
 ___ History of ADD or ADHD?</p> |
|---|--|--|

The information I have provided about my/my child's medical history is accurate to the best of my knowledge.

SIGNATURES OF PARENTS OR GUARDIANS WHERE APPLICABLE _____

DATE _____

Scuba Ranger Release Authorization

Please write the names of individuals other than you that may pick-up your child from this facility and other Scuba Ranger Club Event locations. Also, please write the relationship of the individual to the Scuba Ranger (ex. Sister, Grandmother, Baby Sitter, etc.).

May we release this child to somebody other than you? Yes No

Name: _____

Relationship: _____

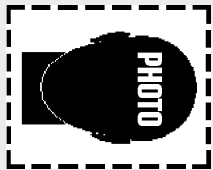
Name: _____

Relationship: _____

Signature: _____

Date: _____

OFFICE USE ONLY



Scuba Rangers №: _____	Date: _____
Certifying Instructor: _____	№: _____
Master Ranger №: _____	Date: _____
Certifying Instructor: _____	№: _____

ALLERGIES: _____

NAME: _____

RELATIONSHIP: _____

PHYSICIAN: _____

PHYSICIAN PHONE: _____

MEDICATIONS: _____

EMERGENCY CONTACT INFORMATION

▲ PARENT LAST ▲ PARENT FIRST ▲ M.I. ▲ PARENT ADDRESS (IF DIFFERENT): STREET ▲ CITY ▲ STATE ▲ ZIP CODE ▲ HOME PHONE ▲ WORK PHONE

