

Experience SCUBA Application



Personal Information				(MM-DD-YYYY)
Surname (last name)			Date of Birth (YYYY-MM-DD) Text	
Given Name(s)				
Mailing Address (Number, Street, Apt.)			City	Province
E-Mail Address				
Home Phone #		Cell Phone #		Business Phone #
Emergency Contact Information				
Surname (last name)			Given Name(s)	
Mailing Address (Number, Street, Apt.)			City	Province
Relationship		Home Phone #		Alternate Phone #

Informed Consent

(Please initial each statement of understanding and sign below. Parent or Guardian must initial each statement as well as the member.)

- _____ I acknowledge that SCUBA diving involves exposures to certain abnormal conditions: underwater submersion, changes in ambient pressure, changes in pressure of inhaled air, and increased stress levels.
- _____ I acknowledge that SCUBA diving involves more risk than ordinary swimming.
- _____ I am aware that, in some circumstances, participation could result in physical injury.
- _____ I am in proper physical condition to participate in SCUBA diving activities.
- _____ I understand that an annual physical examination is advisable when taking part in SCUBA related activities.
- _____ I have completed the annual physical check list and understand that should my physical condition change it is my responsibility to inform in writing the Secretary of the ETOBICOKE UNDERWATER CLUB INC. of these changes.
- _____ I understand that it is my responsibility to make the Convener of an event, Dive Master, Event Co-ordinator, aware of any medical condition that might require special medication or treatment. Should guests have special requirements, it is my responsibility, as their sponsor, to inform in writing the Convener of these conditions.
- _____ I waive any claim that I, my heirs, executors, administrators and assignees may become entitled to for injury or damage to myself or my property while participation in an ETOBICOKE UNDERWATER CLUB INC. sanctioned activity.
- _____ I hereby willingly assume the above mentioned risks of injury or health risks for myself and assume full responsibility during and after my participation in any ETOBICOKE UNDERWATER CLUB INC. sanctioned activities and I therefore hereby release and forever discharge the ETOBICOKE UNDERWATER CLUB INC. its officers and any other organizers, sponsors, representatives, their agents and employees and any other person or organization assisting them in respect to any claims for damages or injuries suffered by me as a result of my participation in or travelling to or from any ETOBICOKE UNDERWATER CLUB INC. sanctioned activities.

I declare that I have read, understood and agreed to the contents of this renewal form.

Dated this _____ day of _____ 20 _____

Signature _____

Parent / Guardian Signature (If individual is under 18 years of age)

MEDICAL STATEMENT

Participant Record (Confidential Information)

Please read carefully before signing.

This is a statement in which you are informed of some potential risks involved in scuba diving and of the conduct required of you during the scuba training program. Your signature on this statement is required for you to participate in the scuba training program offered

by _____ Etobicoke Underwater Club Instructors _____ and
Instructor

_____ Etobicoke Underwater Club _____ located in the
Facility

city of _____ Toronto _____, state/province of _____ Ontario _____.

Read this statement prior to signing it. You must complete this Medical Statement, which includes the medical questionnaire section, to enroll in the scuba training program. If you are a minor, you must have this Statement signed by a parent or guardian.

Diving is an exciting and demanding activity. When performed correctly, applying correct techniques, it is relatively safe. When

established safety procedures are not followed, however, there are increased risks.

To scuba dive safely, you should not be extremely overweight or out of condition. Diving can be strenuous under certain conditions. Your respiratory and circulatory systems must be in good health. All body air spaces must be normal and healthy. A person with coronary disease, a current cold or congestion, epilepsy, a severe medical problem or who is under the influence of alcohol or drugs should not dive. If you have asthma, heart disease, other chronic medical conditions or you are taking medications on a regular basis, you should consult your doctor and the instructor before participating in this program, and on a regular basis thereafter upon completion. You will also 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. You must be thoroughly instructed in its use under direct supervision of a qualified instructor to use it safely.

If you have any additional questions regarding this Medical Statement or the Medical Questionnaire section, review them with your instructor before signing.

Divers Medical Questionnaire

To the Participant:

The purpose of this Medical Questionnaire is to find out if you should be examined by your doctor before participating in recreational diver training. A positive response to a question does not necessarily disqualify you from diving. A positive response means that there is a preexisting condition that may affect your safety while diving and you must seek the advice of your physician prior to engaging in dive activities.

- _____ Could you be pregnant, or are you attempting to become pregnant?
- _____ Are you presently taking prescription medications? (with the exception of birth control or anti-malarial)
- _____ Are you over 45 years of age and can answer YES to one or more of the following?
 - currently smoke a pipe, cigars or cigarettes
 - have a high cholesterol level
 - have a family history of heart attack or stroke
 - are currently receiving medical care
 - high blood pressure
 - diabetes mellitus, even if controlled by diet alone

Have you ever had or do you 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)?
- _____ Other chest disease or chest surgery?
- _____ Behavioral health, mental or psychological problems (Panic attack, fear of closed or open spaces)?
- _____ Epilepsy, seizures, convulsions or take medications to prevent them?
- _____ Recurring complicated migraine headaches or take medications to prevent them?
- _____ Blackouts or fainting (full/partial loss of consciousness)?
- _____ Frequent or severe suffering from motion sickness (seasick, carsick, etc.)?

Please answer the following questions on your past or present medical history with a **YES** or **NO**. If you are not sure, answer **YES**. If any of these items apply to you, we must request that you consult with a physician prior to participating in scuba diving. Your instructor will supply you with an RSTC Medical Statement and Guidelines for Recreational Scuba Diver's Physical Examination to take to your physician.

- _____ Dysentery or dehydration requiring medical intervention?
- _____ Any dive accidents or decompression sickness?
- _____ Inability to perform moderate exercise (example: walk 1.6 km/one mile within 12 mins.)?
- _____ Head injury with loss of consciousness in the past five years?
- _____ Recurrent back problems?
- _____ Back or spinal surgery?
- _____ Diabetes?
- _____ Back, arm or leg problems following surgery, injury or fracture?
- _____ High blood pressure or take medicine to control blood pressure?
- _____ Heart disease?
- _____ Heart attack?
- _____ Angina, heart surgery or blood vessel surgery?
- _____ Sinus surgery?
- _____ Ear disease or surgery, hearing loss or problems with balance?
- _____ Recurrent ear problems?
- _____ Bleeding or other blood disorders?
- _____ Hernia?
- _____ Ulcers or ulcer surgery ?
- _____ A colostomy or ileostomy?
- _____ Recreational drug use or treatment for, or alcoholism in the past five years?

The information I have provided about my medical history is accurate to the best of my knowledge. I agree to accept responsibility for omissions regarding my failure to disclose any existing or past health condition.

Signature

Date

Signature of Parent or Guardian

Date