# SEAL TEAM STATEMENT
## (PADI International Ltd)

**Participant Record (Confidential Information)**

Name _____

Mailing Address _____

City _____

State _____ Country _____ Zip/Postal Code _____

Home Phone (_____) _____ Work Phone (_____) _____

Birth Date _____ Age _____Email_____

**EMERGENCY CONTACT INFORMATION**

Name _____

Home Phone (_____) _____ Work Phone (_____) _____

**Medical History**

**To the participant:**
Answer yes or no to any of the following items that apply to your past medical history or present medical condition. **If any of these items do apply to you, we must request you consult a physician prior to participating in a scuba programme.** Your instructor will supply you with an RSTC Medical Statement and Guidelines for Recreational Scuba Diver's Physical Examination to take to your physician.

__ **Please use Revised medical form on page 3**

**PADI SEAL TEAM STATEMENT OF RISKS AND LIABILITY**

**Please read carefully and fill in all blanks before signing.**

This is a statement in which you are informed of the risks of skin and scuba diving. The statement also sets out the circumstances in which your child participates in the diving programme at your child's own risk.

Your signature on this statement is required as proof that you and your child have received and read this statement. It is important that you read the contents of this statement before signing it. If you do not understand anything contained in this statement, then please discuss it with your child's instructor.

**WARNING**

Skin and scuba diving have inherent risks which may result in serious injury or death.

Diving with compressed air involves certain inherent risks; decompression sickness, embolism or other hyperbaric injury can occur that require treatment in a recompression chamber and your child will be exposed to these risks.

 

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## (PADI International Ltd)

Skin and scuba diving are physically strenuous activities and your child will be exerting themselves during this diving programme. You must advise truthfully and fully inform the dive professionals and the facility through which this programme is offered of your child's medical history.

The PADI Seal Team programme is a series of AquaMissions which will be conducted in a swimming pool. My child may choose to participate in one or all of these AquaMissions. These AquaMissions include, but are not limited to, five (5) core AquaMissions involving the introduction of basic dive skills and ten (10) speciality AquaMissions including Creature ID Specialist, Environmental Specialist, Inner Space Specialist, Navigation Specialist, Night Specialist, Search and Recovery Specialist, Skin Diver Specialist, Snapshot Specialist, Team Safety Specialist and Wreck Specialist.

This Statement also encompasses and applies to all the PADI Seal Team AquaMissions, as described above, in which my child chooses to participate.

**EXCLUSION OF LIABILITY**

I understand and agree that neither the dive professionals conducting this programme, PROFESSIONAL STAFF, nor the facility through which this programme is conducted, OCEANVIEW DIVING SERVICES nor PADI International Ltd., nor PADI Americas, Inc., nor their affiliate or subsidiary corporations, nor any of their respective employees, officers, agents or assigns (hereinafter referred to as "Released Parties") accept any responsibility for any death, injury or other loss suffered or caused by me or resulting from my own conduct or any matter or condition under my control that amounts to my own contributory negligence.

In the absence of any negligence or other breach of duty by the dive professionals conducting this programme, PROFESSIONAL STAFF, the facility through which this programme is offered, OCEANVIEW DIVING SERVICES, PADI International Ltd., PADI Americas, Inc., and all related entities and released parties as defined above, my participation in this diving programme is entirely at my own risk.

I acknowledge receipt of this Statement and have read all of the terms before signing this Statement.

_____
Participant Name (Please Print)

_____ _____
Participant Signature Date (Day/Month/Year)

_____ _____
Signature of Parent/Guardian (where applicable) Date (Day/Month/Year)

# **Diver Medical** | Participant Questionnaire

Recreational scuba diving and freediving requires good physical and mental health. There are a few medical conditions which can be hazardous while diving, listed below. Those who have, or are predisposed to, any of these conditions, should be evaluated by a physician. This Diver Medical Participant Questionnaire provides a basis to determine if you should seek out that evaluation. If you have any concerns about your diving fitness not represented on this form, consult with your physician before diving. If you are feeling ill, avoid diving. If you think you may have a contagious disease, protect yourself and others by not participating in dive training and/or dive activities. References to "diving" on this form encompass both recreational scuba diving and freediving. This form is principally designed as an initial medical screen for new divers, but is also appropriate for divers taking continuing education. For your safety, and that of others who may dive with you, answer all questions honestly.

## Directions

**Complete this questionnaire as a prerequisite to a recreational scuba diving or freediving course.**
**Note to women:** If you are pregnant, or attempting to become pregnant, *do not dive*.

| | | | |
|---|---|---|---|
| **1** | I have had problems with my lungs, breathing, heart and/or blood affecting my normal physical or mental performance. | Yes ☐ Go to box **A** | No ☐ |
| **2** | I am over 45 years of age. | Yes ☐ Go to box **B** | No ☐ |
| **3** | I struggle to perform moderate exercise (for example, walk 1.6 kilometer/one mile in 14 minutes or swim 200 meters/yards without resting), OR I have been unable to participate in a normal physical activity due to fitness or health reasons within the past 12 months. | Yes ☐* | No ☐ |
| **4** | I have had problems with my eyes, ears, or nasal passages/sinuses. | Yes ☐ Go to box **C** | No ☐ |
| **5** | I have had surgery within the last 12 months, OR I have ongoing problems related to past surgery. | Yes ☐* | No ☐ |
| **6** | I have lost consciousness, had migraine headaches, seizures, stroke, significant head injury, or suffer from persistent neurologic injury or disease. | Yes ☐ Go to box **D** | No ☐ |
| **7** | I am currently undergoing treatment (or have required treatment within the last five years) for psychological problems, personality disorder, panic attacks, or an addiction to drugs or alcohol; or, I have been diagnosed with a learning or developmental disability. | Yes ☐ Go to box **E** | No ☐ |
| **8** | I have had back problems, hernia, ulcers, or diabetes. | Yes ☐ Go to box **F** | No ☐ |
| **9** | I have had stomach or intestine problems, including recent diarrhea. | Yes ☐ Go to box **G** | No ☐ |
| **10** | I am taking prescription medications (with the exception of birth control or or anti-malarial drugs other than mefloquine (Lariam). | Yes ☐* | No ☐ |

## Participant Signature

**If you answered NO** to all 10 questions above, a medical evaluation is not required. Please read and agree to the participant statement below by signing and dating it.

**Participant Statement:** I have answered all questions honestly, and understand that I accept responsibility for any consequences resulting from any questions I may have answered inaccurately or for my failure to disclose any existing or past health conditions.

Participant Signature (or, if a minor, participant's parent/guardian signature required.

Date (dd/mm/yyyy)

Participant Name (Print)

Birthdate (dd/mm/yyyy)

PROFESSIONAL STAFF OCEAN VIEW DIVING

OCEAN VIEW DIVING SERVICES

Instructor Name (Print)

Facility Name (Print)

* **If you answered YES** to questions 3, 5 or 10 above **OR** to any of the questions on page 2, please read and agree to the statement above by signing and dating it **AND take all three pages of this form (Participant Questionnaire and the Physician's Evaluation Form) to your physician** for a medical evaluation. Participation in a diving course requires your physician's approval.

**Participant Name** **Birthdate**

(Print) Date (dd/mm/yyyy)

# **Diver Medical** | Participant Questionnaire Continued

| **BOX A – I HAVE/HAVE HAD:** | | |
|---|---|---|
| Chest surgery, heart surgery, heart valve surgery, an implantable medical device (eg, stent, pacemaker, neurostimulator), pneumothorax, and/or chronic lung disease. | Yes ☐* | No ☐ |
| Asthma, wheezing, severe allergies, hay fever or congested airways within the last 12 months that limits my physical activity/exercise. | Yes ☐* | No ☐ |
| A problem or illness involving my heart such as: angina, chest pain on exertion, heart failure, immersion pulmonary edema, heart attack or stroke, OR am taking medication for any heart condition. | Yes ☐* | No ☐ |
| Recurrent bronchitis and currently coughing within the past 12 months, OR have been diagnosed with emphysema. | Yes ☐* | No ☐ |
| Symptoms affecting my lungs, breathing, heart and/or blood in the last 30 days that impair my physical or mental performance. | Yes ☐* | No ☐ |

| **BOX B – I AM OVER 45 YEARS OF AGE AND:** | | |
|---|---|---|
| I currently smoke or inhale nicotine by other means. | Yes ☐* | No ☐ |
| I have a high cholesterol level. | Yes ☐* | No ☐ |
| I have high blood pressure. | Yes ☐* | No ☐ |
| I have had a close blood relative die suddenly or of cardiac disease or stroke before the age of 50, OR have a family history of heart disease before age 50 (including abnormal heart rhythms, coronary artery disease or cardiomyopathy). | Yes ☐* | No ☐ |

| **BOX C – I HAVE/HAVE HAD:** | | |
|---|---|---|
| Sinus surgery within the last 6 months. | Yes ☐* | No ☐ |
| Ear disease or ear surgery, hearing loss, or problems with balance. | Yes ☐* | No ☐ |
| Recurrent sinusitis within the past 12 months. | Yes ☐* | No ☐ |
| Eye surgery within the past 3 months. | Yes ☐* | No ☐ |

| **BOX D – I HAVE/HAVE HAD:** | | |
|---|---|---|
| Head injury with loss of consciousness within the past 5 years. | Yes ☐* | No ☐ |
| Persistent neurologic injury or disease. | Yes ☐* | No ☐ |
| Recurring migraine headaches within the past 12 months, or take medications to prevent them. | Yes ☐* | No ☐ |
| Blackouts or fainting (full/partial loss of consciousness) within the last 5 years. | Yes ☐* | No ☐ |
| Epilepsy, seizures, or convulsions, OR take medications to prevent them. | Yes ☐* | No ☐ |

| **BOX E – I HAVE/HAVE HAD:** | | |
|---|---|---|
| Behavioral health, mental or psychological problems requiring medical/psychiatric treatment. | Yes ☐* | No ☐ |
| Major depression, suicidal ideation, panic attacks, uncontrolled bipolar disorder requiring medication/psychiatric treatment. | Yes ☐* | No ☐ |
| Been diagnosed with a mental health condition or a learning/developmental disorder that requires ongoing care or special accommodation. | Yes ☐* | No ☐ |
| An addiction to drugs or alcohol requiring treatment within the last 5 years. | Yes ☐* | No ☐ |

| **BOX F – I HAVE/HAVE HAD:** | | |
|---|---|---|
| Recurrent back problems in the last 6 months that limit my everyday activity. | Yes ☐* | No ☐ |
| Back or spinal surgery within the last 12 months. | Yes ☐* | No ☐ |
| Diabetes, either drug or diet controlled, OR gestational diabetes within the last 12 months. | Yes ☐* | No ☐ |
| An uncorrected hernia that limits my physical abilities. | Yes ☐* | No ☐ |
| Active or untreated ulcers, problem wounds, or ulcer surgery within the last 6 months. | Yes ☐* | No ☐ |

| **BOX G – I HAVE HAD:** | | |
|---|---|---|
| Ostomy surgery and do not have medical clearance to swim or engage in physical activity. | Yes ☐* | No ☐ |
| Dehydration requiring medical intervention within the last 7 days. | Yes ☐* | No ☐ |
| Active or untreated stomach or intestinal ulcers or ulcer surgery within the last 6 months. | Yes ☐* | No ☐ |
| Frequent heartburn, regurgitation, or gastroesophageal reflux disease (GERD). | Yes ☐* | No ☐ |
| Active or uncontrolled ulcerative colitis or Crohn's disease. | Yes ☐* | No ☐ |
| Bariatric surgery within the last 12 months. | Yes ☐* | No ☐ |

*Physician's medical evaluation required (see page 1).

# **Diver Medical** | Medical Examiner's Evaluation Form

**Participant Name** (Print) **Birthdate** Date (dd/mm/yyyy)

The above-named person requests your opinion of his/her medical suitability to participate in recreational scuba diving or freediving training or activity. Please visit uhms.org for medical guidance on medical conditions as they relate to diving. Review the areas relevant to your patient as part of your evaluation.

## Evaluation Result

☐ Approved – I find no conditions that I consider incompatible with recreational scuba diving or freediving.

☐ Not approved – I find conditions that I consider incompatible with recreational scuba diving or freediving.

Signature of certified medical doctor or other legally certified medical provider

Date (dd/mm/yyyy)

**Medical Examiner's Name**

(Print)

**Clinical Degrees/Credentials**

**Clinic/Hospital**

**Address**

**Phone** **Email**

Physician/Clinic Stamp (optional)

Created by the Diver Medical Screen Committee in association with the following bodies:

**The Undersea & Hyperbaric Medical Society**

**DAN (US)**

**DAN Europe**

**Hyperbaric Medicine Division, University of California, San Diego**