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, blood, or have been diagnosed with COVID-19.	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 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 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)

____
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, stent placement, or a pneumothorax (collapsed lung).	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 ☐
A diagnosis of COVID-19.	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.	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 insulin- 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 | Physician's Evaluation Form

Participant Name ____ Birthdate ______________________
(Print) 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.

____ ______________________
Physican's Signature Date (dd/mm/yyyy)

Physician's Name ____ Specialty ______________________
(Print)

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

IAND, Inc. d.b.a. IANTD TRAINING PROGRAMS

COMPLETE LIABILITY RELEASE AND CONTRACT NOT TO SUE

Name____ Date_____________

Course title _____________________________ Instructor Name ___________________

I UNDERSTAND THE PURPOSE OF SIGNING THIS DOCUMENT IS TO EXEMPT AND RELEASE IANTD/IAND,INC., AS WELL AS MY INSTRUCTORS, AFFILIATED PERSONNEL, THE FACILITY THROUGH WHICH I RECEIVE MY INSTRUCTION, ALL VESSELS (WHETHER OWNED, OPERATED, LEASED OR CHARTERED) AND ALL OTHER INVOLVED PERSONNEL INCLUDING BUT NOT LIMITED TO THEIR OWNERS, EMPLOYEES, CREW, VOLUNTEERS, DESIGNEES, AGENTS, SPONSORS, AND ADVERTISERS (HEREINAFTER THE “RELEASED PARTIES”) AND TO HOLD THESE ENTITIES AND INDIVIDUALS HARMLESS FROM ANY AND ALL LIABILITY ARISING AS A RESULT OF ANY ACTS OR OMISSIONS ON THEIR PART, INCLUDING, BUT NOT LIMITED TO, ACTIVE OR PASSIVE NEGLIGENCE OR NEGLIGENCE *OF ANY TYPE*.

I understand that scuba diving, especially technical diving is a hazardous activity with inherent risks and dangers associated therewith including, but not limited to, training accidents, risks associated with equipment failure, perils of the sea, as well as acts of fellow divers which could result in my serious injury or death. BY WAY OF MY SIGNATURE, I EXPRESSLY ASSUME ALL RISKS OF SCUBA DIVING and all associated risks (whether directly related to diving or not), whether these risks are specifically set forth or not. IT IS MY INTENTION TO RELEASE THE RELEASED PARTIES FOR ANYTHING THAT MAY HAPPEN TO ME WHICH RESULTS IN PERSONAL INJURY OR DEATH.

By my signature on this release, I hereby affirm that I have been advised and informed of the inherent hazards of scuba diving activities, including technical diving. I understand that breathing compressed gas underwater such as; compressed air, oxygen, enriched air (Nitrox), oxygen and/or helium (Trimix and/or Heliox) and/or neon in either Open Circuit, Semi-Closed Circuit or Closed Circuit rebreathers involves inherent risks including, but not limited to, decompression injuries, embolism, oxygen toxicity, inert gas narcosis, marine life injuries and other barotrauma/hyperbaric injuries which can occur that require treatment in a recompression chamber or hospital. I understand that scuba diving trips, which are necessary for training and certification, may be conducted at a site that is remote, either by time or distance or both from a recompression chamber or from any medical facility. Nonetheless, I expressly wish to proceed with this diving activity and assume all risks. I hereby waive any obligation on the part of the released parties to provide first aid, rescue, recovery resuscitation or medical assistance.

I understand that scuba diving activities are physically strenuous and that I will be exerting myself during this scuba diving course and related activities. If I am injured or killed as a result of cardiac events, panic, hyperventilation, oxygen toxicity, inert gas narcosis, drowning, medical events, or for any other reason, I expressly assume all risks and will not hold the released parties responsible for same.

IAND, Inc. d.b.a. IANTD TRAINING PROGRAMS

COMPLETE LIABILITY RELEASE AND CONTRACT NOT TO SUE

I understand that I am signing this release, without modification or any other promises, in consideration of being permitted to enroll in this course and participate in the diving activities.

I will be responsible for inspecting all of my dive equipment prior to each dive to ensure that I have all the necessary equipment for the dive, and that all the equipment is in proper working order with proper and sufficient gas supplies for the dive. I will not hold anyone responsible for my failure to inspect the equipment I use, analyze the gases I use and plan my dive.

IT IS MY EXPRESS INTENTION TO GIVE UP MY RIGHT TO SUE ALL INDIVIDUALS OR ENTITIES OR VESSELS referred to herein ("the released parties") whether specifically named or not, from all liability arising as a consequence of any act or omission including, but not limited to, active or passive negligence of any type. I fully agree to indemnify and hold the released parties harmless from any and all liability for personal injury of any type, including wrongful death. I make this agreement on behalf of myself, my heirs and assigns. I expressly and contractually assume all risks in connection with scuba diving activities whether directly related to diving or not. I understand and agree that it is my responsibility to make my family aware of the risks of injury or death from diving activities, that I accept these risks and choose to participate anyway. I hereby represent that I, or my estate, shall be liable in full for any claim brought on my behalf by my family, estate or heirs, arising from my injury or death while participating in diving activities.

BY WAY OF MY VOLUNTARY SIGNATURE, I AGREE THAT I HAVE FULLY READ AND UNDERSTAND THIS DOCUMENT IN ITS ENTIRETY. **I UNDERSTAND THAT THIS IS A LEGALLY BINDING CONTRACT NOT TO SUE.**

________________________________ ________________________________

Participant's Name (Print) Participant's Signature

Address:____

City:____ State _______

Country _______________________________________ Postal Code _______________

Telephone:_______________________________ Email:___________________________

If the participant is under the age of 18, then the parent or guardian must sign this agreement and agree to be legally bound by it and furthermore be legally responsible for the minor participant, including being responsible for all damage, injury or death which may occur as a result of the minor's participation in diving activities. The parent or guardian hereby agrees to be fully responsibility to the released parties for any damage, injury or death caused by the minor, including actions brought by the minor, for any damages whatsoever.

______________________________ ______________________________

Parent or Guardian's Name (print) Parent or Guardian's Signature