

"I TRIED SCUBA" CLASS RECORD

PLEASE PRINT CLEARLY

NAME _____ BIRTH DATE _____ AGE _____
ADDRESS _____ PHONE _____
CITY _____ STATE _____ ZIP _____
HEIGHT _____ WEIGHT _____ SHOE SIZE _____

STATEMENT OF UNDERSTANDING

"I understand that while SCUBA diving is not a particularly hazardous sport when pursued carefully by properly trained and experienced divers, it does occur in a hazardous environment which can be offset by the development of skills and knowledge acquired through that training and experience. I agree to apply myself to learning as much as possible from this SCUBA course and hold free from any and all liability the YMCA, NAUI and Camp Ohio, its respective officers, employees and instructors. In addition I do hereby for myself, my heirs, executors and, administrators, waive, release and forever discharge any and all rights and claims for damages which may hereafter accrue to me arising out of or connected with my participation in such activity, including but not limited to open water exercises. I also give specific authorization to the Diving Instructor to authorize hospital medical treatment for any diving related malady, should such occur during any water activity."

MEDICAL HISTORY QUESTIONNAIRE

TO THE APPLICANT: You are about to participate in an activity, which places considerable demands on your body. SCUBA diving with medical defects can exacerbate or even cause certain medical problems. This medical history form is designed to allow the applicant and the SCUBA Instructor to assess the physical condition of the applicant, and in some cases to require a physical from a physician to continue. In some cases, items which are of particular concern in SCUBA diving and which may indeed cause problems for the diver and partner will warrant a doctor's examination. Based on your answers to the following questions, a medical examination may be waived or required.

"I have a history of the following condition(s)":

- | | |
|-----------------------------------|------------------------|
| 1. Asthma | 1. Yes _____ No _____ |
| 2. Shortness of Breath | 2. Yes _____ No _____ |
| 3. Persistent or Productive Cough | 3. Yes _____ No _____ |
| 4. Heart or Lung Surgery | 4. Yes _____ No _____ |
| 5. Chest Pain | 5. Yes _____ No _____ |
| 6. Heart Trouble | 6. Yes _____ No _____ |
| 7. Ear, Sinus, or neurosurgery | 7. Yes _____ No _____ |
| 8. Dizzy or Fainting Spells | 8. Yes _____ No _____ |
| 9. Fits or Seizures | 9. Yes _____ No _____ |
| 10. Pneumothorax | 10. Yes _____ No _____ |
| 11. Diabetes | 11. Yes _____ No _____ |
| 12. Tuberculosis | 12. Yes _____ No _____ |
| 13. Rheumatic Fever | 13. Yes _____ No _____ |
| 14. Ruptured Eardrum | 14. Yes _____ No _____ |

SIGNED _____ DATE _____

PARENT OR GUARDIAN IF UNDER 18 _____

WITNESS _____