

MEDICAL STATEMENT

Participant Record (Confidential Information)

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 and/or recreational diving

By: _____ and BLUE O TWO LTD, the
Instructor(s) Divemasters, Dive Guides

BOAT MANAGEMENT COMPANY, the vessel(s) _____, located in the city of HURGHADA, RED SEA, EGYPT.

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.

Please read carefully before signing. 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 pre-existing condition that may affect your safety while diving and you must seek the advice of your physician prior to engaging in dive activities. 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.

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| <input type="checkbox"/> Could you be pregnant, or are you attempting to become pregnant? | <input type="checkbox"/> Blackouts or fainting (full/partial loss of consciousness)? |
| <input type="checkbox"/> Are you presently taking prescription medications (with the exception of birth control or anti-malarial)? | <input type="checkbox"/> Frequent or severe suffering from motion sickness (seasick, carsick, etc.)? |
| <input type="checkbox"/> Are you over 45 years of age and can answer YES to one or more of the following? <ul style="list-style-type: none">• 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 | <input type="checkbox"/> Dysentery or dehydration requiring medical intervention? |
| | <input type="checkbox"/> Any dive accidents or decompression sickness? |
| | <input type="checkbox"/> Inability to perform moderate exercise (example: walk 1.6 km/one mile within 12 mins.)? |
| | <input type="checkbox"/> Head injury with loss of consciousness in the past five years? |
| | <input type="checkbox"/> Recurrent back problems? |
| | <input type="checkbox"/> Back or spinal surgery? |
| | <input type="checkbox"/> Diabetes? |
| | <input type="checkbox"/> Back, arm or leg problems following surgery, injury or fracture? |
| | <input type="checkbox"/> High blood pressure or take medicine to control blood pressure? |
| | <input type="checkbox"/> Heart disease? |
| | <input type="checkbox"/> Heart attack? |
| | <input type="checkbox"/> Angina, heart surgery or blood vessel surgery? |
| | <input type="checkbox"/> Sinus surgery? |
| | <input type="checkbox"/> Ear disease or surgery, hearing loss or problems with balance? |
| | <input type="checkbox"/> Recurrent ear problems? |
| | <input type="checkbox"/> Bleeding or other blood disorders? |
| | <input type="checkbox"/> Hernia? |
| | <input type="checkbox"/> Ulcers or ulcer surgery? |
| | <input type="checkbox"/> A colostomy or ileostomy? |
| | <input type="checkbox"/> Recreational drug use or treatment for, or alcoholism in the past five years? |

Divers Medical Questionnaire

To the Participant:

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