



CAPT STEVE'S SCUBA CONNECTICUT

SCUBA DIVING COURSE STUDENT RECORD

PLEASE PRINT LEGIBLY
ENTER YOUR NAME AS YOU WOULD LIKE IT TO APPEAR ON YOUR
CERTIFICATION CARD

COURSE #: _____

NAME: _____ DOB: _____
First MI Last

PHONE HOME: _____ CELL: _____

EMAIL: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SEX: _____ MARITAL STATUS: _____ AGE: _____

SHIRT/JACKET/DRESS SIZE: _____ SHOE SIZE: _____

EMERGENCY CONTACT: _____

PHONE HOME: _____ CELL: _____

RELATIONSHIP: _____

MEDICAL HISTORY STATEMENT:

I understand that skin and scuba diving are strenuous activities involving significant pressure changes and that normal, healthy heart, lungs, ears and sinuses are essential prerequisites for my safety and well-being. I hereby confirm that to the best of my knowledge and belief my circulatory and respiratory systems and body air spaces are healthy and normal and that I have no severe emotional or neurological problems or communicable diseases. I understand that I need to seek unconditional approval for diving from a licensed physician if I am uncertain as to my physical fitness for the rigors of diving.

Write YES or No next to all of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Behavioral health problems | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Contact lenses |
| <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Dental plates |
| <input type="checkbox"/> Agoraphobia | <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> Physical disability |
| <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Serious injury |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Back/spinal surgery | <input type="checkbox"/> Over 40 years old |
| <input type="checkbox"/> Ear or hearing problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Trouble equalizing pressure | <input type="checkbox"/> Ulcers | <input type="checkbox"/> HIV positive |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Colostomy | <input type="checkbox"/> Regular medication |
| <input type="checkbox"/> Severe hayfever | <input type="checkbox"/> Hernia | <input type="checkbox"/> Drug allergies |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Dizziness or fainting | <input type="checkbox"/> Alcohol or drug abuse |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Recent surgery | <input type="checkbox"/> Rejected from any activity for medical reasons |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Hospitalized | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart surgery | <input type="checkbox"/> May be Pregnant | |
| <input type="checkbox"/> Motion Sickness | <input type="checkbox"/> Any medical condition not listed: _____ | |

List all medications you are presently taking: _____

I certify that the above information is true and correct to the best of my knowledge.

SIGNATURE OF PARTICIPANT (OR PARENT OR GUARDIAN): _____