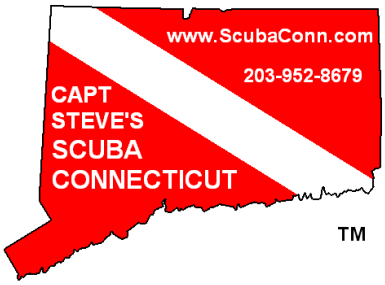

CAPT STEVE'S SCUBA CONNECTICUT

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:

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

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): _____