

PADI Discover Scuba/Discover Scuba Diving Statement Return top portion to PADI for Instructor Credit.

Participant Information (Please Print)

You must register participants within 30 days of their first open water dive.

First Name _____ MI _____ Last Name _____
 Student Mailing Address _____
 City _____ State/Province _____
 Zip/Postal Code _____ Country _____
 Home Phone _____ Email _____
 Date of Birth _____ Gender: Male Female

JAN APR JUL OCT
 FEB MAY AUG NOV
 MAR JUN SEP DEC
 Day Circle appropriate month. Year

Dive Center/Resort Location

PADI Dive Center/Resort No. _____

Photocopy may be used as student referral.
Valid for 12 months from completion date.

Emergency Contact Information

Name _____
 Relationship _____ Phone (_____) _____

PADI Instructor Statement:

PADI Discover Scuba Diving
 I have personally conducted all three phases of the Discover Scuba Diving program (Water Skills Intro and Development and Initial Open Water Dive) as outlined in the PADI Instructor Manual for this participant.

Print Instructor Name First Middle Initial Last

Instructor Signature _____

Date _____ PADI No. _____
Day/Month/Year

PADI Discover Scuba
 This participant has completed all the skills and training from Confined Water Dive One of the PADI Open Water Diver course.

Print Instructor Name First Middle Initial Last

Instructor Signature _____

Date _____ PADI No. _____
Day/Month/Year

PADI EXPERIENCE PROGRAMS MEDICAL STATEMENT

Please read carefully before signing. (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 PADI Experience Programs. Your signature on this statement is required in order to participate in the PADI Experience Programs program offered by _____

_____ (instructor), and _____ (facility),

located in the city of _____ and the state/country of _____.

Read this statement prior to signing it. You must complete this PADI Experience Programs Medical Statement/Questionnaire, which includes the medical history section, to enroll in the PADI Experience Programs. If you are a minor, you must have this PADI Experience Programs Medical Statement/Questionnaire signed by a parent or guardian.

Scuba diving is an exciting and demanding activity. When performed correctly, applying correct techniques, it is safe. When established safety procedures are not followed, however, there are dangers. To scuba dive safely, you must 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 heart trouble, a current cold or congestion, epilepsy, asthma, a severe medical problem, or who is under the influence of alcohol or drugs, should not dive. If taking medication, consult your doctor before participating in this program.

You will also need to 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 or death. You must be thoroughly instructed in its use under the direct supervision of a qualified instructor to use it safely.

MEDICAL QUESTIONNAIRE

To the Participant:

The purpose of this medical questionnaire is to find out if you should be examined by a doctor before participating in recreational scuba diving. A positive response to a question does not necessarily disqualify you from diving. A positive response means that there is a preexisting condition that may affect your safety while diving and you must seek the advice of a physician.

Please answer the following questions on your past and 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 a PADI Medical Statement and Guidelines for Recreational Scuba Diver's Physical Examination to take to a physician.

- _____ Do you currently have an ear infection?
- _____ Do you have a history of ear disease, hearing loss or problems with balance?

- _____ Do you have a history of ear or sinus surgery?
- _____ Are you currently suffering from a cold, congestion, sinusitis or bronchitis?
- _____ Do you have a history of respiratory problems, severe attack of hayfever or allergies, or lung disease?
- _____ Have you had a collapsed lung (pneumothorax) or history of chest surgery?
- _____ Do you have active asthma or history of emphysema or tuberculosis?
- _____ Are you currently taking medication that carries a warning about any impairment of your physical or mental abilities?
- _____ Do you have behavioral health, mental or psychological problems or a nervous system disorder?
- _____ Are you or could you be pregnant?
- _____ Do you have a history of colostomy?
- _____ Do you have a history of heart disease or heart attack, heart surgery or blood vessel surgery?
- _____ Do you have a history of high blood pressure, angina, or take medication to control blood pressure?
- _____ Are you over 45 and have a family history of heart attack or stroke?
- _____ Do you have a history of bleeding or other blood disorders?
- _____ Do you have a history of diabetes?
- _____ Do you have a history of seizures, blackouts or fainting, convulsions or epilepsy or take medications to prevent them?
- _____ Do you have a history of back, arm or leg problems following an injury, fracture or surgery?
- _____ Do you have a history of fear of closed or open spaces or panic attacks (claustrophobia or agoraphobia)?

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.

Name _____

Address _____

Phone (_____) _____

Participant Signature _____ Date _____
Day/Month/Year

Parent/Guardian Signature (where applicable) _____ Date _____
Day/Month/Year