

# Medical declaration for resort diving

To be completed and signed by resort diver

Completing this form is required under section 7 of the Safety in Recreational Water Activities Regulation 2011 before a person can do resort diving.

## Personal details

Surname \_\_\_\_\_ Given names \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Date of birth \_\_\_\_\_ Sex: Male  Female

### Have you suffered, or do you now suffer from, any of the following:

	Yes	No
Asthma or wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Brain, spinal cord or nervous disorder	<input type="checkbox"/>	<input type="checkbox"/>
Chest surgery	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bronchitis or persistent chest complaint	<input type="checkbox"/>	<input type="checkbox"/>
Chronic sinus conditions	<input type="checkbox"/>	<input type="checkbox"/>
Collapsed lung (pneumothorax)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes mellitus (sugar diabetes)	<input type="checkbox"/>	<input type="checkbox"/>
Ear surgery	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Fainting, seizures or blackouts	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease of any kind	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent ear problems when flying	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis or other long-term lung disease	<input type="checkbox"/>	<input type="checkbox"/>

### Are you currently suffering from:

Breathlessness	<input type="checkbox"/>	<input type="checkbox"/>
Chronic ear discharge or infection	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Other illness or operation within the last month	<input type="checkbox"/>	<input type="checkbox"/>
Perforated eardrum	<input type="checkbox"/>	<input type="checkbox"/>

Are you currently taking any medicine or drug (excluding oral contraceptives)?  Yes  No

Have you ingested any alcohol within the 8 hours prior to diving?  Yes  No

Are you pregnant?  Yes  No

Do you understand that concealment of any condition incompatible with safe diving might put your life or health at risk?  Yes  No

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_