

NAUI 2018 STANDARDS AND PROCEDURES POLICY

Medical History Forms and Waiver and Release Agreements. Each student is required to complete a Medical History Form and the NAUI Waiver and Release Agreement by the beginning of training. The beginning of training is defined as the commencement of in-water training activities.

If the medical history form or the appearance of the student indicates any condition contrary to safe participation in diving activities, the student shall be required to obtain medical approval by a licensed physician based on a medical examination prior to any further water training.

The Medical History Forms and the NAUI Waiver and Release Agreements of minors are to be signed by parent(s) and/or legal guardian(s). No in-water scuba instruction shall be provided to a minor without first having secured a release signed by the parent(s) and/or legal guardian(s). In no event will medical approval be accepted wherein the physician signing the certificate is the student.

DIVERS MEDICAL QUESTIONNAIRE TO THE PARTICIPANT

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 preexisting 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.

- _____ Could you be pregnant, or are you attempting to become pregnant?
- _____ Are you presently taking prescription medications with the exception of birth control or anti-malarial?
- _____ Are you over 45 years of age AND can answer YES to one or more of the following?
- 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

Have you ever had or do you currently have...

- _____ Asthma, or wheezing with breathing, or wheezing with exercise?
- _____ Frequent or severe attacks of hay-fever or allergy?
- _____ Frequent colds, sinusitis or bronchitis?
- _____ Any form of lung disease?
- _____ Pneumothorax (collapsed lung)?
- _____ Other chest disease or chest surgery?
- _____ Behavioral health, mental or psychological problems (Panic attack, fear of closed or open spaces)?
- _____ Epilepsy, seizures, convulsions or take medications to prevent them?
- _____ Recurring complicated migraine headaches or take medications to prevent them?

- _____ Blackouts or fainting (full/partial loss of consciousness)?
- _____ Frequent or severe suffering from motion sickness (seasick, carsick, etc.)?
- _____ Dysentery or dehydration requiring medical intervention?
- _____ Any dive accidents or decompression sickness?
- _____ Inability to perform moderate exercise (example: walk 1.6 km/one mile within 12 minutes)?
- _____ Head injury with loss of consciousness in the past five years?
- _____ Recurrent back problems?
- _____ Back or spinal surgery?
- _____ Diabetes?
- _____ Back, arm or leg problems following surgery, injury or fracture?
- _____ High blood pressure or take medicine to control blood pressure?
- _____ Heart disease?
- _____ Heart attack?
- _____ Angina, heart surgery or blood vessel surgery?
- _____ Sinus surgery?
- _____ Ear disease or surgery, hearing loss or problems with balance?
- _____ Recurrent ear problems?
- _____ Bleeding or other blood disorders?
- _____ Hernia?
- _____ Ulcers or ulcer surgery ?
- _____ A colostomy or ileostomy?
- _____ Recreational drug use or treatment for, or alcoholism in the past five years

If you answered "YES" please download the form for your physician here: <https://goo.gl/eJVc2M>