Participant Information

Your personal information is required for PADI's Quality Management Process. Please complete the following details using Black or Blue ink in CAPITAL letters.

Name _____ Sex ❑ M ❑ F
First Middle Initial Last

Mailing Address _____

City _____ Region _____

Post Code _____ Country _____

Phone (_____) _____ Work Phone (_____) _____

Email _____ Birth Date _____
Day/Month/Year

Data Protection

ATTENTION: PADI Professionals – This statement must be acknowledged by the student before they can be registered.

How the information about you will be used: Your details will be held by PADI Europe AG or PADI International Limited and used to manage your application. They may also be shared with other PADI affiliated companies for administration purposes. For more details regarding how your information will be used please see our Privacy Policy which can be found at padi.com

We would like to contact you with information about PADI diving products, services and promotions by email, SMS, post or phone. If you do not want to be contacted in this way please tick this box. ❑

We would also like to share your information with affiliated PADI companies, PADI Dive Stores, other diving related companies and selected third parties that we think would be of interest to you, so that they may contact you with information about their products, services, and promotions by email, SMS, post or phone. If you agree we may pass on your details to these organisations please tick this box. ❑

Training Record

ATTENTION: PADI Professionals – Please tick the relevant box and fill in only the section that has been completed under your direct supervision.

❑ Discover Scuba Diving experience

PADI Member Name:	PADI No:	Date:

❑ Confined Water Dive One

PADI Instructor Name:	PADI No:	Date:

❑ Open Water Dive One

PADI Instructor Name:	PADI No:	Date:

How to easily register your Discover Scuba Diving Participants Online:

1. Log on to the PADI Pros' area of padi.com - Pro Login
2. Click the Members' Toolbox (old Pros' area) / Online Services (new Pros' area)
3. Click Discover Scuba Diving Registration (DSD)
4. Fill in the details

Remember, registering Discover Scuba Diving participants entitles both the PADI Member and Dive Centre to student credits.

Alternatively you can photocopy this page and mail it to:
DSD Registrations, PADI Europe AG, Oberwilerstrasse 3, CH-8442 Hettlingen, Switzerland

Discover Scuba Diving Safe Diving Practices Statement

These practices have been compiled for your review and acknowledgment and are intended to increase your comfort and safety in diving.

- I understand that upon completing the Discover Scuba Diving programme, I will not be qualified to dive independently without a certified professional guiding me.
- To equalize my ears and sinus air spaces, I will need to blow gently against pinched nostrils every few feet/one metre while descending.
- If I have discomfort in my ears or sinuses during descent, I should stop my descent and alert my instructor.
- Underwater, I should breathe slowly, deeply, continuously and never hold my breath.
- I should respect underwater life and not touch, tease or harass an underwater organism since it may harm me and/or I may harm it.
- I can seek further training from any PADI Dive Centre, Resort and Instructor to become certified to dive without a professional guide.

Statement of Risks and Liability

I (participant name), _____, hereby affirm that I am aware that skin and scuba diving have inherent risks which may result in serious injury or death.

I affirm I have read and understand the Safe Diving Practices and have had any questions answered to my satisfaction. I understand the importance and purposes of these established practices. I recognise they are for my safety and well being, and that failure to adhere to them can place me in jeopardy when diving.

I understand that diving with compressed air involves certain inherent risks; decompression sickness, embolism or other hyperbaric injury can occur that require treatment in a recompression chamber. I further understand that this programme may be conducted at a site that is remote, either by time or distance or both, from such a recompression chamber. I still choose to proceed with this programme in spite of the absence of a recompression chamber in proximity to the dive site.

The information I have provided about my medical history on the Medical Questionnaire 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 conditions. I further understand that skin diving and scuba diving are physically strenuous activities and that I will be exerting myself during this programme.

I further state that I am of lawful age and legally competent to sign this Statement of Risks and Liability, or that I have acquired the written consent of my parent or guardian.

I understand and agree that neither the dive professionals conducting this programme, _____ PROFESSIONAL STAFF, nor the facility through which this programme is conducted, _____ Ocean View Diving Services, nor PADI Europe AG, PADI International Ltd., nor PADI Americas, Inc., nor their affiliate or subsidiary corporations, nor any of their respective employees, officers, agents or assigns (hereinafter referred to as "Released Parties") accept any responsibility for any death, injury or other loss suffered or caused by me or resulting from my own conduct or any matter or condition under my control that amounts to my own contributory negligence.

In the absence of any negligence or other breach of duty by the dive professionals conducting this programme, PROFESSIONAL STAFF, the facility through which this programme is offered, Ocean View Diving Services, PADI Europe AG, PADI International Ltd., PADI Americas, Inc., and all released entities and released parties as defined above, my participation in this diving programme is entirely at my own risk.

I have fully informed myself of the contents of this Statement of Risks and Liability by reading it before signing it.

_____
Participant Name

_____ Date _____
Participant Signature Day/Month/Year

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

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____ Phone (_____) _____

Diver Medical | Participant Questionnaire

Recreational scuba diving and freediving requires good physical and mental health. There are a few medical conditions which can be hazardous while diving, listed below. Those who have, or are predisposed to, any of these conditions, should be evaluated by a physician. This Diver Medical Participant Questionnaire provides a basis to determine if you should seek out that evaluation. If you have any concerns about your diving fitness not represented on this form, consult with your physician before diving. If you are feeling ill, avoid diving. If you think you may have a contagious disease, protect yourself and others by not participating in dive training and/or dive activities. References to "diving" on this form encompass both recreational scuba diving and freediving. This form is principally designed as an initial medical screen for new divers, but is also appropriate for divers taking continuing education. For your safety, and that of others who may dive with you, answer all questions honestly.

Directions

Complete this questionnaire as a prerequisite to a recreational scuba diving or freediving course.
Note to women: If you are pregnant, or attempting to become pregnant, *do not dive*.

1	I have had problems with my lungs, breathing, heart and/or blood affecting my normal physical or mental performance.	Yes ☐ Go to box **A**	No ☐
2	I am over 45 years of age.	Yes ☐ Go to box **B**	No ☐
3	I struggle to perform moderate exercise (for example, walk 1.6 kilometer/one mile in 14 minutes or swim 200 meters/yards without resting), OR I have been unable to participate in a normal physical activity due to fitness or health reasons within the past 12 months.	Yes ☐*	No ☐
4	I have had problems with my eyes, ears, or nasal passages/sinuses.	Yes ☐ Go to box **C**	No ☐
5	I have had surgery within the last 12 months, OR I have ongoing problems related to past surgery.	Yes ☐*	No ☐
6	I have lost consciousness, had migraine headaches, seizures, stroke, significant head injury, or suffer from persistent neurologic injury or disease.	Yes ☐ Go to box **D**	No ☐
7	I am currently undergoing treatment (or have required treatment within the last five years) for psychological problems, personality disorder, panic attacks, or an addiction to drugs or alcohol; or, I have been diagnosed with a learning or developmental disability.	Yes ☐ Go to box **E**	No ☐
8	I have had back problems, hernia, ulcers, or diabetes.	Yes ☐ Go to box **F**	No ☐
9	I have had stomach or intestine problems, including recent diarrhea.	Yes ☐ Go to box **G**	No ☐
10	I am taking prescription medications (with the exception of birth control or or anti-malarial drugs other than mefloquine (Lariam).	Yes ☐*	No ☐

Participant Signature

If you answered NO to all 10 questions above, a medical evaluation is not required. Please read and agree to the participant statement below by signing and dating it.

Participant Statement: I have answered all questions honestly, and understand that I accept responsibility for any consequences resulting from any questions I may have answered inaccurately or for my failure to disclose any existing or past health conditions.

Participant Signature (or, if a minor, participant's parent/guardian signature required.

Date (dd/mm/yyyy)

Participant Name (Print)

Birthdate (dd/mm/yyyy)

PROFESSIONAL STAFF OCEAN VIEW DIVING

OCEAN VIEW DIVING SERVICES

Instructor Name (Print)

Facility Name (Print)

* **If you answered YES** to questions 3, 5 or 10 above **OR** to any of the questions on page 2, please read and agree to the statement above by signing and dating it **AND take all three pages of this form (Participant Questionnaire and the Physician's Evaluation Form) to your physician** for a medical evaluation. Participation in a diving course requires your physician's approval.

Participant Name **Birthdate**

(Print) Date (dd/mm/yyyy)

Diver Medical | Participant Questionnaire Continued

BOX A – I HAVE/HAVE HAD:		
Chest surgery, heart surgery, heart valve surgery, an implantable medical device (eg, stent, pacemaker, neurostimulator), pneumothorax, and/or chronic lung disease.	Yes ☐*	No ☐
Asthma, wheezing, severe allergies, hay fever or congested airways within the last 12 months that limits my physical activity/exercise.	Yes ☐*	No ☐
A problem or illness involving my heart such as: angina, chest pain on exertion, heart failure, immersion pulmonary edema, heart attack or stroke, OR am taking medication for any heart condition.	Yes ☐*	No ☐
Recurrent bronchitis and currently coughing within the past 12 months, OR have been diagnosed with emphysema.	Yes ☐*	No ☐
Symptoms affecting my lungs, breathing, heart and/or blood in the last 30 days that impair my physical or mental performance.	Yes ☐*	No ☐

BOX B – I AM OVER 45 YEARS OF AGE AND:		
I currently smoke or inhale nicotine by other means.	Yes ☐*	No ☐
I have a high cholesterol level.	Yes ☐*	No ☐
I have high blood pressure.	Yes ☐*	No ☐
I have had a close blood relative die suddenly or of cardiac disease or stroke before the age of 50, OR have a family history of heart disease before age 50 (including abnormal heart rhythms, coronary artery disease or cardiomyopathy).	Yes ☐*	No ☐

BOX C – I HAVE/HAVE HAD:		
Sinus surgery within the last 6 months.	Yes ☐*	No ☐
Ear disease or ear surgery, hearing loss, or problems with balance.	Yes ☐*	No ☐
Recurrent sinusitis within the past 12 months.	Yes ☐*	No ☐
Eye surgery within the past 3 months.	Yes ☐*	No ☐

BOX D – I HAVE/HAVE HAD:		
Head injury with loss of consciousness within the past 5 years.	Yes ☐*	No ☐
Persistent neurologic injury or disease.	Yes ☐*	No ☐
Recurring migraine headaches within the past 12 months, or take medications to prevent them.	Yes ☐*	No ☐
Blackouts or fainting (full/partial loss of consciousness) within the last 5 years.	Yes ☐*	No ☐
Epilepsy, seizures, or convulsions, OR take medications to prevent them.	Yes ☐*	No ☐

BOX E – I HAVE/HAVE HAD:		
Behavioral health, mental or psychological problems requiring medical/psychiatric treatment.	Yes ☐*	No ☐
Major depression, suicidal ideation, panic attacks, uncontrolled bipolar disorder requiring medication/psychiatric treatment.	Yes ☐*	No ☐
Been diagnosed with a mental health condition or a learning/developmental disorder that requires ongoing care or special accommodation.	Yes ☐*	No ☐
An addiction to drugs or alcohol requiring treatment within the last 5 years.	Yes ☐*	No ☐

BOX F – I HAVE/HAVE HAD:		
Recurrent back problems in the last 6 months that limit my everyday activity.	Yes ☐*	No ☐
Back or spinal surgery within the last 12 months.	Yes ☐*	No ☐
Diabetes, either drug or diet controlled, OR gestational diabetes within the last 12 months.	Yes ☐*	No ☐
An uncorrected hernia that limits my physical abilities.	Yes ☐*	No ☐
Active or untreated ulcers, problem wounds, or ulcer surgery within the last 6 months.	Yes ☐*	No ☐

BOX G – I HAVE HAD:		
Ostomy surgery and do not have medical clearance to swim or engage in physical activity.	Yes ☐*	No ☐
Dehydration requiring medical intervention within the last 7 days.	Yes ☐*	No ☐
Active or untreated stomach or intestinal ulcers or ulcer surgery within the last 6 months.	Yes ☐*	No ☐
Frequent heartburn, regurgitation, or gastroesophageal reflux disease (GERD).	Yes ☐*	No ☐
Active or uncontrolled ulcerative colitis or Crohn's disease.	Yes ☐*	No ☐
Bariatric surgery within the last 12 months.	Yes ☐*	No ☐

*Physician's medical evaluation required (see page 1).

Diver Medical | Medical Examiner's Evaluation Form

Participant Name (Print) **Birthdate** Date (dd/mm/yyyy)

The above-named person requests your opinion of his/her medical suitability to participate in recreational scuba diving or freediving training or activity. Please visit uhms.org for medical guidance on medical conditions as they relate to diving. Review the areas relevant to your patient as part of your evaluation.

Evaluation Result

☐ Approved – I find no conditions that I consider incompatible with recreational scuba diving or freediving.

☐ Not approved – I find conditions that I consider incompatible with recreational scuba diving or freediving.

Signature of certified medical doctor or other legally certified medical provider

Date (dd/mm/yyyy)

Medical Examiner's Name

(Print)

Clinical Degrees/Credentials

Clinic/Hospital

Address

Phone **Email**

Physician/Clinic Stamp (optional)

Created by the Diver Medical Screen Committee in association with the following bodies:

The Undersea & Hyperbaric Medical Society

DAN (US)

DAN Europe

Hyperbaric Medicine Division, University of California, San Diego