HUKA DIVING

Medical Survey

Name: _____ Birthdate: _____
(Print Full Name) (Day/Month/Year)

Address: _____
(Print complete address) (Zip or country code)

Phone Number: ( ) _____ Email: _____

Emergency Contact: _____
(Print Full Name)

Emergency Contact Phone Number: ( ) _____

Please answer the following questions on your past or present medical history with a YES or NO. If any of these items apply to you, we must request that you consult with a physician prior to participating in HUKA diving. Your instructor will supply you with a medical statement guidelines for recreational Huka diver's physical examination to take you physician.

_____ Are you more than 3 months pregnant?

_____ Do you have a history of heart attacks or strokes?

_____ Do you have asthma or wheezing with breathing or exercise?

_____ Do you currently have a cold, sinusitis, or bronchitis?

_____ Do you have any form of lung disease?

_____ Do you have epilepsy, seizures, convulsions, or take medications to prevent them?

_____ Do you have a history of blackouts or fainting?

_____ Do you have high blood pressure or take medicine to control it?

_____ Have you ever had heart surgery, angina, or blood vessel surgery?

_____ Do you have any history of diabetes affecting your ability to participate in a strenuous activity?

_____ Are you currently under the influence of drugs or alcohol?

_____ Do you have a history of ear or sinus surgery?

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

_____ Do you have problems equalizing (popping) ears with airplane or mountain travel?

If you have answered Yes to any of the above questions, you must be cleared to HUKA dive by a physician.

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 conditions.

Signature: _____ Date: _____

Signature of Guardian (where applicable): _____ Date: _____

Student

(PLEASE PRINT LEGIBLY)

Name: _____ Birthdate: _____ Age: _____
First Initial Last

Mailing Address: _____

City: _____ State/Province: _____

Country: _____ Zip/Postal Code: _____

Home Phone: ( ) _____

Business Phone: ( ) _____

Email: _____

Name and address of your family or primary care physician:

Physician: _____ Clinic/Hospital: _____

Address: _____ Phone: ( ) _____

Date of last physical examination: _____

Name of examiner: _____ Clinic/Hospital: _____

Address: _____ Phone: ( ) _____

Were you ever required to have a physical for diving Yes No If so, when? _____

_____

Physician

This person is an applicant for training or is presently certified to engage in HUKA Diving. Your opinion of the applicant's medical fitness for HUKA diving is requested. Please review guidelines for Recreational Scuba Diver's Physical Examination.

Physician's Impression

_____ I find no medical condition that I consider incompatible with diving.

_____ I am unable to recommend this individual for diving.

Remarks

I have reviewed Guidelines Recreational Scuba Diver's Physical Examination.

Physician's Signature: _____, M.D. Date _____

Physician: _____ Clinic/Hospital: _____

Address: _____

Phone: ( ) _____