

# SSI Try Scuba & Diving SCUBA SCHOOLS INTERNATIONAL RECORD CARD

## Personal Information:

Name \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ Country \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  Male  Female Phone (H) \_\_\_\_\_ : (W) \_\_\_\_\_  
 Email Address \_\_\_\_\_  
 Leader Name \_\_\_\_\_ No. \_\_\_\_\_ Agency \_\_\_\_\_

## In Case of Emergency, Contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (H) \_\_\_\_\_ : (W) \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

## Begin Your Adventure! Become an SSI Open Water Diver.

Diving is the greatest sport imaginable. It's fun for everyone, regardless of your age, level of ability, or the level of adventure you want. It's perfect for families, couples and singles.

Talk to your instructor about enrolling in a scuba course so you can get certified to dive anytime you want. Or find an SSI Training Facility near your home at [www.diveSSI.com](http://www.diveSSI.com).

## Medical History

### To the Participant:

The purpose of this medical questionnaire is to find out if you should be examined by your licensed medical practitioner 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 pre-existing condition that may affect your safety while diving and you must seek the advice of your licensed medical practitioner.

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 licensed medical practitioner prior to participating in scuba diving. Your Instructor will supply you with a medical statement and guidelines for recreational scuba diver's physical examination to take to your licensed medical practitioner.

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

Do you have a family history of heart attack or stroke and are you 45 years or older? \_\_\_\_\_  
 High cholesterol level \_\_\_\_\_  
 Have a family history of heart attacks or strokes \_\_\_\_\_  
 Are you pregnant or do you suspect you may be pregnant? \_\_\_\_\_  
 Asthma, or wheezing with breathing, or wheezing with exercise? \_\_\_\_\_  
 Frequent or severe attacks of hayfever or allergy? \_\_\_\_\_  
 Frequent colds, sinusitis or bronchitis? \_\_\_\_\_  
 Any form of lung disease? \_\_\_\_\_  
 Pneumothorax (collapsed lung)? \_\_\_\_\_  
 History of chest surgery? \_\_\_\_\_  
 Claustrophobia or agoraphobia (fear of closed or open spaces)? \_\_\_\_\_

### Behavioral health problems?

\_\_\_\_\_ Epilepsy, seizures, convulsions or take medications to prevent them?  
 \_\_\_\_\_ History of blackouts or fainting (full/partial loss of consciousness)?  
 \_\_\_\_\_ History of diabetes?  
 \_\_\_\_\_ History of back, arm or leg problems following surgery, injury or fracture?  
 \_\_\_\_\_ History of any heart disease?  
 \_\_\_\_\_ History of heart attacks?  
 \_\_\_\_\_ Angina or heart blood vessel surgery?  
 \_\_\_\_\_ History of ear or sinus surgery?  
 \_\_\_\_\_ History of ear disease, hearing loss or problems with balance?  
 \_\_\_\_\_ History of bleeding or other blood disorders?  
 \_\_\_\_\_ History of colostomy?

The information I have provided about my medical history is accurate to the best of my knowledge.

▲ SIGNATURE \_\_\_\_\_

▲ DATE \_\_\_\_\_