
# "I Tried SCUBA" Waiver/Release

Name: _____ Birth Date ___/___/___ Age ____

Month/Day/Year *Minimum age requirement Age 10*

Address _____ City _____ State ZIP _____

Phone # (___) _____ E-Mail Address: _____

***Information below CRUCIAL for sizing of SCUBA gear***

Height: ___ ft ___ in Weight: ___ lbs. T-shirt size: _____ Shoe Size:

Statement of Understanding and Release

"I understand that while SCUBA diving is not a particularly hazardous sport when pursued carefully by properly trained and experienced divers, it does occur in a hazardous environment which can be offset by the development of skills and knowledge acquired through that training and experience. I agree to apply myself to learning as much as possible form this introductory scuba course and hold free from any and all liability the YMCA, its respective officers, employees and instructors, and do hereby for myself, my heirs, and executors and administrators, waive, release, and forever discharge any and all rights and claims for damages which may hereafter accrue to me arising out of or connected with my participation in such activities, including open water activities, and in addition to give specific authorization to the Diving Instructor to authorize hospital medical treatment for any diving related malady, should such occur during any water activity."

Medical History Questionnaire

To the Applicant: You are about to participate in an activity that places considerable demands on your body. SCUBA diving with medical defects can exacerbate or even cause certain medical problems. This medical history form is designed to allow the applicant and the SCUBA Instructor to assess the physical condition of the applicant, and in some cases to require a physical from a physician to continue. In some cases, items which are of particular concern in scuba diving and which may indeed cause problems for the diver and partner, will warrant a doctor's examination. Based on you answers to the following questions a medical examination may be waived or required.

"I have a history of the following condition(s)." (Please mark with "yes" or "no" ... check marks are not sufficient)

1._____Asthma
2._____ Shortness of breath
3._____Persistent or Productive cough
4._____ Heart or Lung surgery
5._____Chest pain
6._____ Heart trouble
7._____Ear, sinus, or neurosurgery
8._____ Dizzy or fainting spells
9._____ Fits or seizures
10._____ Pneumothorax (collapsed lung)
11._____ Diabetes/High Blood Pressure
12._____ Tuberculosis
13._____ Rheumatic fever
14._____ Ruptured eardrum

Signature:_____Date:_____

Parent or Guardian if under 18_____