



SCUBA EXPERIENCE REGISTRATION FORM

Participant Information - Please print clearly within the boxes provided.

Fill bubbles completely.

YOUR PRIVACY IS IMPORTANT TO US. WE DO NOT SELL OR GIVE AWAY ANY PERSONAL INFORMATION

____ / ____ / _____

Program Completion Date (Day/Mon/Year)

First Name

MI

Last Name

Date of Birth

- Jan
- Feb
- Mar
- Apr
- May
- Jun
- Jul
- Aug
- Sep
- Oct
- Nov
- Dec

Year

Email

Participant Mailing Address

Participant Mailing Address

City

State/Province

Zip/Postal Code

Phone

Country

Gender: Male
 Female

For Instructor and Dive Center Use Only

Dive Verification

Member Number

Dive Center/Resort Number

Program Location

Member's Name (Please Print)

Member's Signature

Date (Day/Mon/Year)



WAIVER AND RELEASE OF LIABILITY ASSUMPTION OF RISK AND INDEMNITY AGREEMENT

— This form is to be used for Try Scuba Diving Training —

In consideration of permitting me, _____ to enroll in
(PARTICIPANT'S NAME)
a snorkeling/scuba diving instructional course and/or participate in snorkeling/scuba diving activities and
related operations conducted by The Professional Staff at Ocean First Divers through the facility
(DIVE LEADER'S NAME)
of OCEAN FIRST DIVERS in the city of BOULDER in the County of
(DIVE BUSINESS NAME)
BOULDER, and State of COLORADO beginning on the _____ day of (month)
_____, 20____, I, for myself, my personal representatives, heirs and next of kin:

HEREBY acknowledge that **SNORKELING/SCUBA DIVING IS A POTENTIALLY DANGEROUS ACTIVITY** and involves the risk of serious injury and/or death and/or property damage. **I FURTHER ACKNOWLEDGE** that diving with compressed air involves certain risks and injuries that can occur which require treatment in a recompression chamber or other facility which may require a great distance of travel. **I UNDERSTAND** that the open water diving trips which are necessary for training and certification or for other diving activities may be conducted at a site that is remote, either by time or distance or both, from a recompression chamber or medical facilities.

HEREBY RELEASE, WAIVE, DISCHARGE AND AGREE NOT TO SUE Scuba Schools International, the above dive business, its facility, the dive leader, or any of its officers, instructors, agents or employees (the Releasees) **FROM ALL LIABILITY TO MYSELF**, my personal representatives, assigns, heirs, and next of kin **FOR ANY AND ALL LOSS OR DAMAGE, AND ANY CLAIM OR DEMANDS THEREFOR ON ACCOUNT OF INJURY TO MY PERSON OR PROPERTY OR RESULTING IN MY DEATH, NOW AND FOREVER, ARISING OUT OF OR RELATED TO PARTICIPATION AND/OR INSTRUCTION IN SAID COURSE, ACTIVITIES, OR ANY OTHER RELATED DIVING OPERATIONS THAT MAY OCCUR, WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEES OR OTHERWISE.**

HEREBY ASSUME FULL RESPONSIBILITY FOR ANY RISK OF BODILY INJURY, DEATH OR PROPERTY DAMAGE, now and forever, arising out of or related to participation and/or instruction in said course, activities, or any other related diving operations, whether foreseen or unforeseen and whether caused by the negligence of the Releasees or otherwise, **I HEREBY SEPARATELY** agree to **INDEMNIFY** and **SAVE** and **HOLD HARMLESS** the Releasees from any loss, liability, damage or cost that they may incur, now and forever, arising out of or related to participation and/or instruction in said course, activities, or any other related diving operations, whether caused by the negligence of the Releasees or otherwise.

HEREBY acknowledge that **INJURIES RECEIVED MAY BE COMPOUNDED OR INCREASED BY NEGLIGENT RESCUE OPERATIONS OR PROCEDURES OF THE RELEASEES** and agree that this Waiver and Release of Liability, Assumption of Risk and Indemnity Agreement extends to all acts of negligence by Releasees, **INCLUDING NEGLIGENT RESCUE OPERATIONS** and is intended to be as broad and inclusive as permitted by the laws of the Province or State in which the activities are conducted and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

I have read this Waiver and Release of Liability, Assumption of Risk and Indemnity Agreement, fully understand its terms, understand that I have given up substantial rights by signing it, am aware of its legal consequences, and have signed it freely and voluntarily without any inducement, assurance, or guarantee being made to me and intend my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law. I have had the opportunity to personally discuss with the dive leader the potential dangers incidental to engaging in the course and/or activity of snorkeling or scuba diving and related diving operations.

Participant's Name _____
▲ (PLEASE PRINT)

▲ (SIGNATURE REQUIRED)

Witness _____ Date _____

*As parent or guardian, I am signing this document on behalf of my minor child and agree to be specifically bound to all the terms and conditions of this Agreement. I have read the agreement, fully understand the terms herein, understand that I have given up substantial rights by signing it, am aware of its legal consequences, and have signed this document freely and voluntarily without any inducement, assurance or guarantee being made to me. I intend my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law and further agree to indemnify and save and hold harmless Releasees. Additionally, I understand the risks of injury while snorkeling or scuba diving and have had the opportunity to personally discuss the diving activities or instructional program with the Dive Leader prior to commencement of the minor child's snorkeling or scuba activities. **

Mother's Name _____
▲ (PLEASE PRINT)

▲ (SIGNATURE REQUIRED) ▲ (DATE)

Father's Name _____
▲ (PLEASE PRINT)

▲ (SIGNATURE REQUIRED) ▲ (DATE)

Guardian's Name _____
▲ (PLEASE PRINT)

▲ (SIGNATURE REQUIRED) ▲ (DATE)

*** NOTE:** This Waiver and Release of Liability, Assumption of Risk and Indemnity Agreement is to be signed by the minor child as a participant, as well as by one or both parents or the guardian.

Medical Statement

PARTICIPANT RECORD — CONFIDENTIAL INFORMATION

Please read carefully before signing.

This is a statement in which you are informed of some potential risks involved in scuba diving and of the conduct required of you during the scuba training program. Your signature on this statement is required for you to participate in the scuba training program offered by:

(INSTRUCTOR) The Professional Staff
 and (FACILITY) OCEAN FIRST DIVERS
 located in the city of BOULDER
 and state of COLORADO.

Read and discuss this statement prior to signing it. You must complete this Medical Statement, which includes the medical-history section, to enroll in the scuba training program. If you are a minor, you must have this Statement signed by a parent.

Diving is an exciting and demanding activity. When performed correctly, applying correct techniques, it is very safe. When established safety procedures are not followed, however, there

are dangers.

To scuba dive safely, you must not be extremely overweight or out of condition. Diving can be strenuous under certain conditions. Your respiratory and circulatory systems must be in good health. All body air spaces must be normal and healthy. A person with heart trouble, a current cold or congestion, epilepsy, asthma, a severe medical problem, or who is under the influence of alcohol or drugs should not dive. If taking medication, consult your doctor and the Instructor before participation in this program. You will also need to learn from the Instructor the important safety rules regarding breathing and equalization while scuba diving. Improper use of scuba equipment can result in serious injury. You must be thoroughly instructed in its use under direct supervision of a qualified Instructor to use it safely.

If you have any additional questions regarding this Medical Statement or the Medical History section, review them with your Instructor before signing.

Medical History

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 pre-existing condition that may affect your safety while diving and you must seek the advice of your physician.

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 a medical statement and guidelines for recreational scuba diver's physical examination to take to your physician.

- | | | |
|--|---|--|
| <input type="checkbox"/> Could you be pregnant, or are you attempting to become pregnant? | <input type="checkbox"/> Any form of lung disease? | <input type="checkbox"/> Head injury with loss of consciousness in the past five years? |
| <input type="checkbox"/> Are you presently taking prescription medications? (with the exception of birth control or anti-malarial) | <input type="checkbox"/> Pneumothorax (collapsed lung)? | <input type="checkbox"/> Recurrent back problems? |
| <input type="checkbox"/> Are you over 45 years of age and can answer YES to one or more of the following? | <input type="checkbox"/> Other chest disease or chest surgery? | <input type="checkbox"/> Back or spinal surgery? |
| • currently smoke a pipe, cigars, or cigarettes | <input type="checkbox"/> Behavioral health, mental or psychological problems (panic attack, fear of closed or open spaces)? | <input type="checkbox"/> Diabetes? |
| • have a high cholesterol level | <input type="checkbox"/> Epilepsy, seizures, convulsions or take medications to prevent them? | <input type="checkbox"/> Back, arm or leg problems following surgery, injury or fracture? |
| • have a family history of heart attacks or strokes | <input type="checkbox"/> Recurring migraine headaches or take medications to prevent them? | <input type="checkbox"/> High blood pressure or take medication to control blood pressure? |
| • are currently receiving medical care | <input type="checkbox"/> Blackouts or fainting (full/partial loss of consciousness)? | <input type="checkbox"/> Heart disease? |
| • high blood pressure | <input type="checkbox"/> Frequent or severe suffering from motion sickness (seasick, carsick, etc.)? | <input type="checkbox"/> Heart attack? |
| • diabetes mellitus, even if controlled by diet alone | <input type="checkbox"/> Dysentery or dehydration requiring medical intervention? | <input type="checkbox"/> Angina, heart surgery or blood vessel surgery? |
| | <input type="checkbox"/> Any dive accidents or decompression sickness? | <input type="checkbox"/> Sinus surgery? |
| | <input type="checkbox"/> Inability to perform moderate exercise (example: walk 1.6 km/one mile within 12 mins.)? | <input type="checkbox"/> Ear disease or surgery, hearing loss or problems with balance? |
| | | <input type="checkbox"/> Recurrent ear problems? |
| | | <input type="checkbox"/> Bleeding or other blood disorders? |
| | | <input type="checkbox"/> Hernia? |
| | | <input type="checkbox"/> Ulcers or ulcer surgery? |
| | | <input type="checkbox"/> A colostomy or ileostomy? |
| | | <input type="checkbox"/> Recreational drug use or treatment for, or alcoholism in the past five years? |

HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE...

- Asthma, or wheezing with breathing, or wheezing with exercise?
- Frequent or severe attacks of hayfever or allergy?
- Frequent colds, sinusitis or

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 condition.

SIGNATURE

DATE

SIGNATURES OF PARENTS OR GUARDIANS WHERE APPLICABLE

DATE

Student

(Please print legibly)

Name _____ Birth Date _____ Age _____
First Initial Last

Mailing Address _____

City _____ State/Province _____

Country _____ Zip/Postal Code _____

Home Phone () _____ Business Phone () _____

Telex _____ FAX _____

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 scuba (self contained underwater breathing apparatus) diving. Your opinion of the applicant's medical fitness for scuba diving is requested. Please review Guidelines for Recreational Scuba Diver's Physical Examination.

Physician's Impression:

I find no medical conditions that I consider incompatible with diving.

I am unable to recommend this individual for diving.

Remarks _____

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

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

Physician _____ Clinic/Hospital _____

Address _____ Phone () _____