



# Ultimate Diver Challenge, LLC.

10507 College Ave. Kansas City, MO 64137

(816) 765-SCUBA

www.ultimatediverchallenge.com

## Medical Release Waiver

Dive Participant Information		
<i>Last</i>	<i>First</i>	<i>MI</i>
<i>Address</i>		<i>Phone</i>
<i>City</i>	<i>State</i>	<i>Zip</i>
Medical History		
<p>The purpose of this medical questionnaire is to find out if a physician should examine the diver before participating in this event. A positive response to a question does not necessarily disqualify the individual from participating. A positive response means that there is a preexisting condition that may affect the individual's safety while diving and you must seek the advice of a physician. Please answer the following questions on your past or present medical history with a <b>Yes</b> or <b>No</b>. If you are not sure, answer <b>Yes</b>. If any of these items apply to you, we must request that you consult with a physician prior to participating in this event.</p>		
<input type="checkbox"/> Are you pregnant or do you suspect that you might be pregnant? <input type="checkbox"/> Do you regularly take prescription or non-prescription medications?	<input type="checkbox"/> Claustrophobia or agoraphobia (fear of closed or open spaces)? <input type="checkbox"/> Behavioral health problems? <input type="checkbox"/> Epilepsy, seizures, convulsions or take medications to prevent them? <input type="checkbox"/> Recurring migraine headaches or take medications to prevent them?	<input type="checkbox"/> History of blackouts or fainting (full/partial loss of consciousness)? <input type="checkbox"/> Do you frequently suffer from motion sickness (seasick, carsick, etc)? <input type="checkbox"/> History of diving accidents or decompression sickness? <input type="checkbox"/> History of recurrent back problems? <input type="checkbox"/> History of back surgery? <input type="checkbox"/> history of diabetes? <input type="checkbox"/> History of back, arm or leg problems following surgery, injury or fracture? <input type="checkbox"/> Inability to perform moderate exercise (walk one mile within 12 minutes)?
<b>Have you had or do you currently have...</b>		
<input type="checkbox"/> Asthma, or wheezing with breathing, or wheezing with exercise? <input type="checkbox"/> Frequent or severe attacks of hay fever or allergy? <input type="checkbox"/> Frequent colds, sinusitis or bronchitis? <input type="checkbox"/> Any form of lung disease? <input type="checkbox"/> Pneumothorax (collapsed lung)? <input type="checkbox"/> History of being born premature and having to be on oxygen or needing mechanical ventilation? <input type="checkbox"/> History of congenital heart problems such as a heart murmur during the newborn period that should have resolved?		



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### Medical Release Waiver Cont.

#### Medical History

##### Medical History Cont.

- History of high blood pressure or take medications to control blood pressure?
- History of chest surgery?
- History of any heart disease?
- History of hear attacks?
- Angina or heart blood vessel surgery?
- History of ear drainage other then wax?
- History of ear or sinus surgery?
- PE tubes or surgery to patch an ear drum from a PE tube or perforation that did not heal?
- History of ear disease, hearing loss or problems with balance?
- History of problems equalizing (popping) ears with airplane or mountain travel?
- History of bleeding or other blood disorders?
- History of any type of hernia?
- History of ulcers or ulcer surgery?
- History of colostomy?
- Frequent nose bleeds or history of having a nose bleed thereafter because it would not stop bleeding?
- History o ADD or ADHD?

#### Disclaimer and Signature

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

Print

Sign

Date