centro de buceo delfín

Name and surname ____

HEALTH STATUS QUESTIONNAIRE FOR RECREATIONAL DIVING PRACTICE

Diving requires good physical and mental health. There are some medical conditions that can be dangerous while diving, which are listed below. Those who have or are predisposed to any of these conditions should be evaluated by a doctor. This Diver Physician Questionnaire provides a basis for determining whether you should seek such an evaluation. If you have any concerns about your physical condition for diving and they are not represented on this form, consult your doctor before diving. References to "diving" on this form cover both self-contained recreational diving and freediving. This form is primarily designed as an initial medical examination for new divers, but is also appropriate for divers who receive continuing education. For your safety and that of others who can dive with you, answer all questions honestly.

INSTRUCTIONS

Complete this questionnaire as a prerequisite for freediving or freediving with autonomous equipment.
Note to women: If you are pregnant, or trying to become pregnant, do not dive.

1. I have had problems with my lungs or breathing, heart or Yes No blood.	Yes ☐ Go to table A	NO ☐
2.I am over 45 years	Yes ☐ Go to table B	No ☐
3. I find it difficult to do moderate exercise (for example, walk 1.6 Yes O No kilometers in 12 minutes or swim 200 meters without resting), or I have not been able to participate in normal physical activity due to physical or health reasons in the last 12 months.	Yes ☐ *	No ☐
4.I had problems with my eyes,ears or sinusils	Yes ☐ Go to table C	No ☐
5. I have/had surgery in the last 12 months, or have ongoing problems related to previous surgery.	Yes ☐ *	No ☐
6. I have lost consciousness, have had migraine headaches, have seizures, stroke, significant head injury, or have suffered from persistent neurological injury or disease.	Yes ☐ Go to table D	No ☐
7. I have/had psychological problems, I was diagnosed with a learning disability, personality disorder, panic attacks or a drug or alcohol addiction.	Yes ☐ Go to table E	No ☐
8. I have had back problems, hernia, ulcers, or diabetes.	Yes ☐ Go to table F	No ☐

9. I have had stomach or intestinal problems, including recent diarrh.	Yes ☐ Go to table G	No ☐
10.I am taking prescription medications (with the exception of contraceptive or antimalarial medications).	Yes ☐ *	No ☐

If you answered NO to the above 10 questions, a medical evaluation is not required. Please read and accept the participant statement below with the date and your signature.

PARTICIPANT STATEMENT: I have answered all questions honestly, and I understand that I accept responsibility for any consequence resulting from any question that may have been inaccurately answered or for not having disclosed any existing or past health condition.

Signature (if you are a minor, signature of the father / mother / legal guardian):

Date: ____________________

Name and surname: ____

Date of birth: ______________________

Instructor´s name: ____

Name of dive center: ____

IF YOU ANSWERED YES TO QUESTIONS 3, 5 or 10 PREVIOUS OR TO ANY OF THE QUESTIONS ON PAGES 3 AND 4, please read and accept the above statement dated and signed, and take the Physician Evaluation Form to your physician for a MEDICAL EVALUATION.

Participation in a diving training program requires the evaluation and approval of your doctor.

Name and Surname____

TABLE A – I Have/ have had

Thoracic surgery, cardiac surgery, heart valve surgery, placement of a "stent" or pneumothorax (collapsed lung).	Yes ☐ *	No ☐
Asthma, wheezing, severe allergies, hay fever, or congested airways in the past 12 months that limits my physical activity or exercise.	Yes ☐ *	No ☐
A problem or disease involving my heart such as: angina, chest pain on exertion, heart failure, pulmonary edema, cardiomyopathy, stroke, or I am taking Sif medications for any heart condition.	Yes ☐ *	No ☐
Recurrent bronchitis and persistent cough in the last 12 months, or have been diagnosed with emphysema.	Yes ☐ *	No ☐

TABLE B – I am over 45 years old

I currently smoke or inhale nicotine by other means, I have a high cholesterol level, I have high blood pressure.	Yes ☐ * Ye ☐ * Yes ☐ *	No ☐ No ☐ No ☐
I have had a parent who died of sudden death or heart disease or stroke Not before age 50 (including abnormal heart rhythms, disease [of the coronary arteries or cardiomyopathy)	Yes ☐ *	No ☐

TABLE C – I have / have had:

Sinus surgery in the last 6 months.	Yes ☐ *	No ☐
Diseases of the ear or ear surgery, hearing loss or disturbances of balance.	Yes ☐ *	No ☐
Recurrent sinusitis in the last 12 months.	Yes ☐ *	No ☐
Eye surgery in the last 3 months	Yes ☐ *	No ☐

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Name and Surname____

TABLE D – I have/Have had:

Head injury with loss of consciousness in the last 5 years.	Yes ☐ *	No ☐
No Persistent neurological injuries or diseases	Yes ☐ *	No ☐
No Recurrent migraine headaches in the last 12 months, or I take medication to prevent them.	Yes ☐ *	No ☐
Fainting (total / partial loss of consciousness) in the last 5 years.	Yes ☐ *	No ☐
Epilepsy, seizures or seizures, or taking medications to prevent them.	Yes ☐ *	No ☐

TABLE E – I have / had have:

Behavioral health, mental or psychological problems that require medical or psychiatric treatment.	Yes ☐ *	No ☐
Major depression, suicidal tendency, panic attacks, uncontrolled bipolar disorder If psychiatric medication / treatment is require	Yes ☐ *	No ☐
I have been diagnosed with a mental health condition or a learning or development disorder that requires continued attention.	Yes ☐ *	No ☐
An addiction to drugs or alcohol that requires treatment in the past 5 years.	Yes ☐ *	No ☐

TABLE F – I have / had have:

Recurrent back problems in the last 6 months that limit my daily activity.	Yes ☐ *	No ☐
Spinal surgery in the last 12 months.	Yes ☐ *	No ☐
Diabetes, whether controlled by insulin or diet, or gestational diabetes in the last 12 months.	Yes ☐ *	No ☐
An uncorrected hernia that limits my physical abilities.	Yes ☐ *	No ☐
Active or untreated ulcers, problem wounds or ulcer surgery in the last 6 months.	Yes ☐ *	No ☐

Name and Surname____

TABLE G – I have:

Ostomy surgery and I do not have medical authorization to swim or participate in physical activity.	Ye ☐ *	No☐
Dehydration that requires medical intervention in the last 7 days.	Ye ☐ *	No☐
Active or untreated stomach or intestinal ulcers or ulcer surgery in the last 6 months.	Ye ☐ *	No☐
Frequent heartburn, regurgitation, or reflux disease If gastroesophageal	Ye ☐ *	No☐
Active or uncontrolled ulcerative colitis or Crohn's disease.	Ye ☐ *	No☐
Bariatric surgery in the last 12 months.	Ye ☐ *	No☐

Name and Surname ____

In compliance with Regulation (EU) 2016/679, the European Parliament and the Council, of April 27, 2016 (hereinafter RGPD), Espigón Norte Cullera SL reveals this policy regarding the treatment and protection of data Personal:

1.You are the sole owner of your data and we will only process your data when we are authorized to do so.

2. Purposes: On behalf of the company we trot the information that you provide us in order to provide the requested service and perform the billing thereof,

3. Data retention: We will keep your data while our commercial and / or contractual relationship is in force , and subsequently for the fulfillment of our legal obligations, remaining at the exclusive disposal of Judges and Courts, the Public Prosecutor's Office or the competent Public Administrations, in particular the data protection authorities, for the attention of possible responsibilities arising from the treatment, during the limitation period of these. The data will not be transferred to third parties except in cases where there is a legal obligation.
4. Responsible for the teatment: The person responsible for the trotamiento of their dotos is Espigón Norte Cullera St, with CIF B40561995, and pastoral address Avenida de la Guardia Civil number 11 of the town of Cullera (Valencia), with phone number 961721634 and email diving@delfincullera.com

SIGN:

DIVER MEDICAL REPORT

Name ____

Date of birth __________________________

(Capital Letters) Date (dd/mm/aaaa)

The person named above requests your opinion on their medical suitability to participate in the training or activity of dive,

Result of Apt Assessment -

☐ Apt - I do not find conditions that I consider incompatible with the dive.

☐ No Apt – I find conditions that I consider incompatible with diving.

____ _____________________

Doctor sign Date (dd/mm/aaa)

Doctor´s Name __________________________________

Speciality ____

(Capital Letters)

Medical Center _______________________________

Address ____

Phone ________________ Email _____________________