DISCOVER SNORKELLING/SKIN DIVING STATEMENT OF RISKS AND LIABILITY

Participant Record (Confidential Information)

.

Name _____

Mailing Address _____

City _____

State _____ Country_____ Zip/Postal Code _____

Home Phone (_____) _____ Work Phone (_____) _____

Birth Date _____ Age _____

Please read carefully and fill in all the blanks before signing.

This is a statement in which you are informed of the risks of snorkeling and skin diving. The statement also sets out the circumstances in which you participate in the snorkeling / skin diving programme at your own risk.

Your signature on this statement is required as proof that you have received and read this statement. It is important that you read the contents of this statement before signing it. If you do not understand anything contained in this statement, then please discuss it with your dive professional. If you are a minor, this form must also be signed by a parent or guardian.

WARNING

Snorkeling and skin diving have inherent risks which may result in serious injury or death. Snorkeling and skin diving are physically Strenuous activities and you will be exerting yourself during this programme. You must advise truthfully and fully inform the dive professionals and the facility through which this programme is offered of your medical history.

EXCLUSION OF LIABILITY

Past or present medical conditions may be contradictive to my participation in the programme. I affirm that I am not currently suffering from a cold or congestion or have an ear infection. I affirm that I do not have a history of seizures, dizziness or fainting; nor a history or heart condition (e.g. cardiovascular disease angina, heat attack). I further affirm that I do not have a history of respiratory problems such as asthma, emphysema, or tuberculosis. I affirm that I am not currently taking medication that carries a warning about any impairment of my physical or mental abilities.

I understand and agree that neither the dive professionals conducting this programme, _____, nor the facility through which this programme is conducted, ___DIVE_DOMINICA_LTD____, nor PADI Americas inc, nor their affiliate or subsidiary corporations nor any of their respective employees, officers, agents or assigns (hereinafter referred to as “Released Parties”) accept any responsibility for any death, injury or other loss suffered or caused by me or resulting from my own conduct or any matter or condition under my control that amounts to my own contributory negligence.

In the absence of my negligence or other breach of duty the dive professionals conducting this programme,_____, the facility through which this programme is offered, _DIVE_DOMINICA__LTD.___, PADI International Ltd, PADI Americas Inc., and all related entities and released parties as defined above, my participation in this snorkeling/skin diving programme is entirely at my own risk.

I acknowledge receipt of this Statement and have read all of the terms before signing this Statement.

_____
Participant Name (Please Print)

_____ _____
Participant Signature Date (Day/Month/Year)

_____ _____
Signature of parent/Guardian (where applicable) Date (Day/Month/Year)

DIVE DOMINICA
P.O. BOX 63
COMMONWEALTH OF DOMINICA
W.I.

MEDICAL HISTORY

Please check off any of the following statements which might apply to you:

1. _____ I'm currently suffering from some form of cold or congestion.
2. _____ I have a history of some form of serious respiratory disease (tuberculosis, emphysema, asthma, etc.)
3. _____ I have a history of some form of serious cardiovascular disease (heart attack/stroke, etc…)
4. _____ I have a condition which may cause sudden loss of consciousness (epilepsy, diabetes, etc…)
5. _____ I have had an injury or illness which has affected my hearing or ears, or I have difficulty with my ears while flying.
6. _____ I have a physical handicap which impairs my ability to move my arms, legs or some other part of the body.
7. _____ I take some form of regular medication.
8. _____ I suffer from allergic reactions to certain things.
9. _____ I sometimes suffer from motion sickness.
10. _____ I sometimes suffer from claustrophobia.
11. _____ I smoke a pack or more of cigarette a day.
12. _____ I wear glasses or contacts
13. _____ I wear dentures
14. _____ I am or may be pregnant

If you checked any of items 1-8, please write an explanation below for each item(s) checked.

Number Explanation

_____ _____

_____ _____

_____ _____

Age _____ Date of Birth _____ Sex _____

In case of Emergency, contact: (Please supply as much information as you can)

Name _____ Relationship _____

Address

_____

_____

Phone _____

PLEASE COMPLETE BOTH SIDES