INTERNATIONAL ASSOCIATION for HANDICAPPED DIVERS

Hazelaarlaan 47 1775 EE Middenmeer Netherlands Tel(+31) 0227 503631 Fax(+31) 0227 503729, E-mail: info@iahd.org

Please read carefully and fill in all open spaces before signing.

I,_____, hereby acknowledge that I have been thoroughly informed
First & Last name
and advised of the potential risk of skin diving and scuba diving.
Further, I understand that diving with compressed air involves certain risks: decompression sickness, embolism, or other hyperbaric injuries can occur that require treatment in a recompression chamber. I further understand that the open water diving activities, which are necessary for training and for certification, may be conducted at a site that is remote, either by time or distance or both, from such a recompression chamber. I still choose to proceed with such instructional dives in spite of the possible absence of a recompression chamber in proximity of the dive site.
I understand and agree that neither my instructor(s), _____,
Lastname and certification number
the facility through which I received my instruction, _____,
Facility name and place
nor the IAHD worldwide Ltd, nor its affiliate and subsidiary corporations, nor any of their respective employees, officers, agents, or assigns, (hereinafter referred to as "Released Parties") may be held liable in any way for any injury, death, or other damages to me or my family, heirs, or assigns that may occur as a result of my participation in this diving program or as a result of the negligence of any party , including the Released Parties, whether passive or active.
In consideration of being allowed to enrol in this IAHD training program, I hereby personally assume all risks in connection with said IAHD program, for any harm, injury or damage that may befall me while I am enrolled as a student of this IAHD program including all risks connected therewith, whether foreseen or unforeseen.
I further save and hold harmless said IAHD program and Released Parties from any claim or lawsuit by me, my family, estate, heirs, or assigns, arising out of my enrolment and participation in this IAHD program including both claims arising during the program or after I receive my certification.
I also understand that skin diving and scuba diving are physically strenuous activities and that I will be exerting myself during this diving program, and that if I am injured as a result of a heart attack, panic, hyperventilation, etc., that I expressly assume the risk of said injuries and that I will not hold the above listed individuals or companies responsible for the same.
I further state that I am of lawful age and legally competent to sign this liability release, or that I have acquired the written consent of my parent or guardian.
I understand that the terms herein are contractual and not a mere recital, and that I have signed this document of my own free act.
It is the intention of _____ by this instrument to exempt and release my instructor(s), _____, the facility through which I received my training, _____, and the IAHD worldwide Ltd, and all related entities as defined above, from all liability or responsibility whatsoever for personal injury, property damage or wrongful death however caused, including, but not limited to, the negligence of the released parties, whether passive or active.
I have fully informed myself of the contents of this liability release and express assumption of risk by reading it before I signed it on behalf of myself and my heirs.

_____ _____
Participants signature Date: day month year

_____ _____
Signature of parent or guardian (where applicable) Date: day month year

Attach a copy of official proof of identification. Signed form should be kept by instructor or training facility for a minimum of 7 years, or as long as required by local law.

Medical examination / assessment of Sport Divers
(confidential information)

- Please complete all relevant sections and tick box(es) where appropriate.
- Write clearly and please print.
- Completed forms should be send with application and a copy should be saved by the Diver.

Diver's personal details:

Last name _____ First name _____

Date of Birth _____ Sex: Female ☐ Male ☐

Address _____

Nationality _____ Level of Disability _____

Type of Medical:

Preliminary Examination ☐ Renewal Examination ☐

Date of examination _____ Date of expiry _____

Is the diver medically fit to dive? Yes ☐ No ☐

If Yes, are there any restrictions? Yes ☐ No ☐

If Yes, please explain _____

Examining Doctor's details:

Name _____ Stamp _____

Address _____

Date _____

Signature _____

Before you become engaged with scuba diving activities it is important that you are aware of some of the potential risks involved. Diving is an exciting and demanding activity. When performed correctly, applying correct techniques, it is very safe. When however, established safety procedures are not followed there are dangers.
To scuba dive safely, you should endeavour to maintain good health. Avoid being excessively overweight, and avoid being in poor physical condition. All your body air spaces must be effective and healthy. A person who suffers from any severe medical problem, is in ill health, or does not feel well should not dive. If you are taking medication, consult your doctor and your instructor before participating in any activity.
Your instructor will teach you the important safety rules regarding scuba diving. Improper use of scuba equipment can result is serious injury. In order to dive safely you must be thoroughly familiar with your equipment and know how to use it correctly.

General Information.

Are you a swimmer?	Yes	☐	No	☐
Do you have snorkelling/diving experience?	Yes	☐	No	☐
Do you have any swimming, snorkelling or diving diploma's?	Yes	☐	No	☐

Medical History.
For your own safety and in accordance with IAHD standards, you are required to consult with a physician prior to participating in scuba diving. Please complete all three pages prior to your medical examination. Take this form with you to your physician so that after examining you, she/he may complete and sign the section on page 1 of this form.

Could you be pregnant or are you attempting to become pregnant?	Yes	☐	No	☐
Do you regularly take prescription or non prescription medications? (with exception of birth control)	Yes	☐	No	☐
Are you over 45 years of age and have one or more of the following:				
Currently smoke a pipe, cigar or cigarette?	Yes	☐	No	☐
Have a high cholesterol level?	Yes	☐	No	☐
Have a family history of heart attacks or strokes?	Yes	☐	No	☐

If you are disabled through illness or injury, how long ago did it happen? _____
Should you answer YES to any of the questions below, please give a brief explanation where necessary.
Do you:
Use a catheter? _____ Type: _____
Have any time had decubitus ulcers (pressure sores)? _____If YES, when? _____
Present condition? _____
Have a respiratory disorder? _____ If YES, explain: _____
Have any problems with your ability to perspire? _____ If YES, explain: _____
Suffer from heat loss problems, thermoregulation?_____If YES, explain: _____
Have any loss of muscle control in the mouth or lips? _____If YES, explain: _____
Suffer from spasms? _____
Suffer from Deep Vein Thrombosis (DVT)? _____
Suffer from Dysreflexia? _____ If YES, can you treat yourself? _____
If not, will you have someone present who can? _____
Have any speech impairment?_____
Have any hearing loss? _____
Have any allergies? _____
Please state any other medical problem(s) not covered: _____

Have you ever had or do you currently suffer from:

Asthma or wheezing with breathing, or wheezing with exercise?	Yes	☐	No	☐
Frequent or severe attacks of hay fever?	Yes	☐	No	☐
Frequent colds, sinusitis or bronchitis?	Yes	☐	No	☐
Any form of lung disease?	Yes	☐	No	☐
Pneumothorax (collapsed lung)?	Yes	☐	No	☐
A history of chest surgery?	Yes	☐	No	☐
Claustrophobia or agoraphobia (fear of closed or open spaces)?	Yes	☐	No	☐
Behavioural health problems?	Yes	☐	No	☐
Epilepsy, seizures, convulsions or take medication to prevent them?	Yes	☐	No	☐
Recurring migraine headaches or take medication to prevent them?	Yes	☐	No	☐
A history of blackouts or fainting (full/partial loss of consciousness)?	Yes	☐	No	☐
Motion sickness (seasick, carsick, etc.)?	Yes	☐	No	☐
Problems with your cough reflex or intercostal muscles?	Yes	☐	No	☐
A history of diving accidents or decompression sickness?	Yes	☐	No	☐
A history of recurrent back problems?	Yes	☐	No	☐
A history of back surgery?	Yes	☐	No	☐
A history of diabetes?	Yes	☐	No	☐
Any back, arm or leg problems after surgery, injure or fracture?	Yes	☐	No	☐
An inability to perform moderate exercises?	Yes	☐	No	☐
Any high blood pressure or take medication for controlling it?	Yes	☐	No	☐
A history of any heart attacks?	Yes	☐	No	☐
Angina or heat surgery or blood vessel surgery?	Yes	☐	No	☐
A history of heart disease?	Yes	☐	No	☐
A history of ear or sinus surgery?	Yes	☐	No	☐
A history of ear disease, hearing loss or problems with balance?	Yes	☐	No	☐
Any problems equalising your ears with air or mountain travel?	Yes	☐	No	☐
A history of bleeding or other disorders?	Yes	☐	No	☐
Any loss of sensory responses (feeling)?	Yes	☐	No	☐
A history of any type of hernia?	Yes	☐	No	☐
A history of ulcers or ulcer surgery?	Yes	☐	No	☐
A history of drug or alcohol abuse?	Yes	☐	No	☐
A history of colostomy?	Yes	☐	No	☐

The information I have given above is accurate to the best of my knowledge.

Name: _____ Date: _____

_____

signature signature of parent or guardian if applicable

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Training Forwarding Form

Please use this form when you wish to finish your **IAHD** training at a different place with a different **IAHD** Instructor.
This form may be used for the Open Water, Advanced Open Water, Dive Partner and Dive Leader programs.

Please type or print clearly.

NAME: _____ **BIRTH DATE:**_____
First Initial Last Day / Month / Year

MAILING ADDRESS:_____

POSTAL:_____**CITY:**_____ **Country:** _____

COURSE:_____

Academic Training: All academics have to be completed with 1 instructor using materials from 1 Training agency supplemented with **IAHD** materials where applicable.

System used:_____ **Date completed:**_____
PADI/SSI/NAUI/BSAC/IAHD/etc. Day / Month / Year

Name Instructor:_____ **IAHD nr.:**_____

I hereby certify that the above information is true and correct to the best of my knowledge

Instructor signature: _____Date._____
Day / Month / Year

Confined water training: All confined water training have to be completed with 1 instructor.

Date completed:_____
Day / Month / year

Name Instructor:_____ **IAHD nr.:**_____

I hereby certify that the above information is true and correct to the best of my knowledge

Instructor signature: _____ Date._____
Day / Month / Year

All training should be completed within 6 months from the original start of the course.
Last instructor will sign the DCA.

Please enclose the following with this application:

1. Original **IAHD** DCA.

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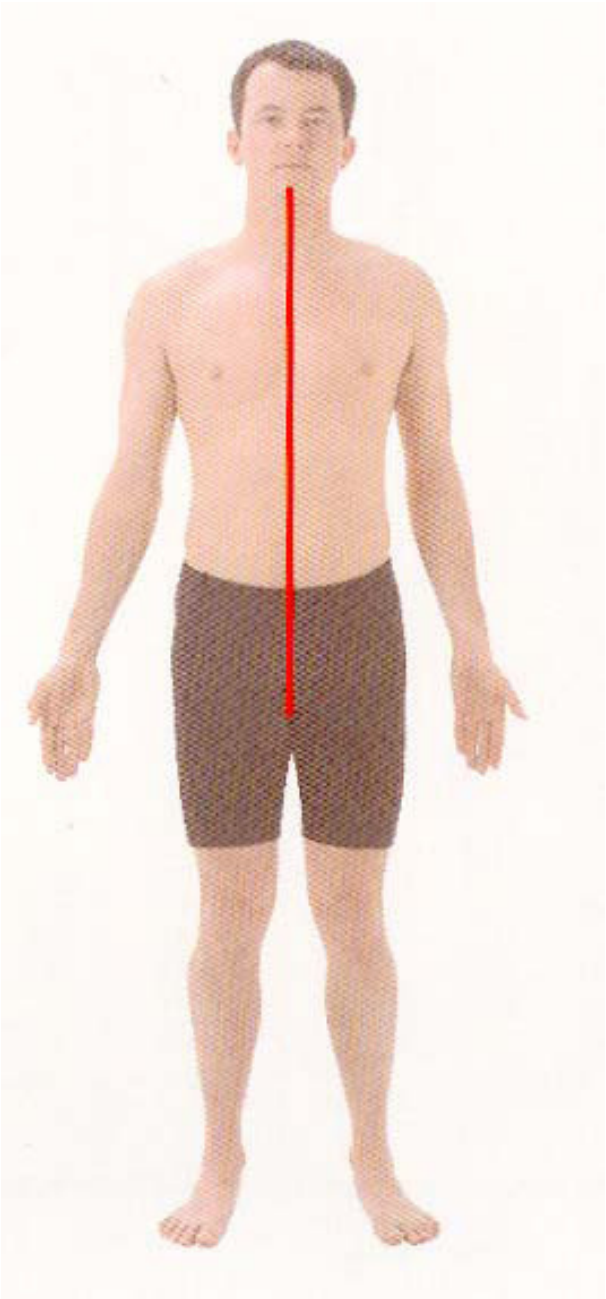
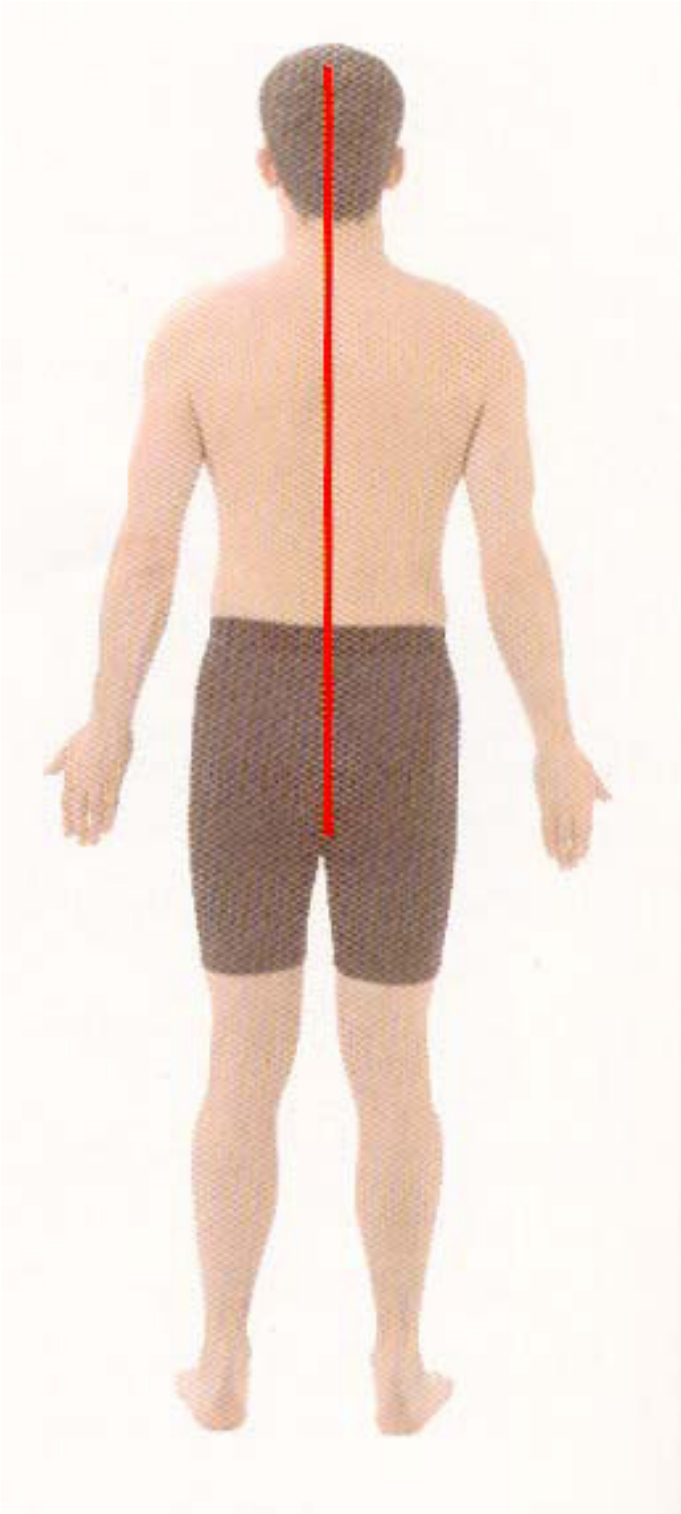
Weight Placement map

Name:	Pool	Thermal Protection:
	Fresh Water	
	Salt Water	





Make a copy of this sheet for the student to save with her / his logbook. Keep a copy in your student file also for future reference.