

# Scuba Diving Medical Consent Form

## Personal Information

Full Name

Date of Birth

Address

Contact Number

Email

## Medical History

List any medical conditions

List any current medications

List any allergies

Previous surgeries/hospitalizations

## Declaration

I confirm that the above information is accurate to the best of my knowledge. I understand the risks involved in scuba diving and give my consent to participate in scuba diving activities.

Signature

Date

