

Scuba Diving Trip Health Declaration Form

Personal Information

Full Name

Date of Birth

Nationality

Phone Number

Email

Emergency Contact

Contact Name

Contact Phone

Relationship

Medical History

- ☐ Asthma or lung disease
- ☐ Heart disease or high blood pressure
- ☐ Diabetes
- ☐ Epilepsy, seizures, or fainting
- ☐ Ear or sinus surgery/infection
- ☐ Currently pregnant
- ☐ Recent surgery or major injury
- ☐ Taking prescribed medication
- ☐ Other medical conditions

If yes to any above, please provide details

Diving Information

Certification Agency & Level

Number of Logged Dives

Date of Last Dive

Declaration & Signature

I declare that the information provided is accurate and complete. I acknowledge understanding of the risks associated with scuba diving and agree to participate at my own risk.

Signature

Date