14th International Submarine Races - Participant Medical History - Form 5.4

To the Participant:

The purpose of this medical questionnaire is to find out if you should be examined by your doctor before participating in this event.

Please answer the following questions on your past or present medical history with a **YES** or **NO**. If you are not sure, answer **YES**. If any of these items apply to you, we must request that you consult with a physician prior to participating in this event.

____ Are you pregnant or do you suspect you may be pregnant?
____ Do you regularly take prescription or nonprescription medications? (with the exception of birth control)
____ Are you over 45 years of age ***and*** have one or more of the following?
- currently smoke a pipe, cigars, or or cigarettes
- have a high cholesterol level
- have a family history of heart attacks or strokes

____ History of diving accidents or decompression sickness?
____ History of diabetes?
____ Inability to perform moderate exercise (walk one mile within 12 minutes)?
____ History of any heart disease?
____ Angina or heart blood vessel surgery?
____ History of ear disease, hearing loss or problems with balance?
____ History of bleeding or blood disorders?
____ History of ulcers or ulcer surgery?
____ History of drug or alcohol abuse?
____ History of chest surgery?
____ Claustrophobia or agoraphobia (fear of closed or open spaces)?
____ Behavioral health problems?
____ Epilepsy, seizures, convulsions or take medications to prevent them?
____ Recurring migraine headaches or take medications to prevent them?
____ History of blackouts or fainting (full/partial loss of consciousness)?
____ Do you frequently suffer from motion sickness (seasick, carsick, etc.)?
____ History of recurrent back problems?
____ History of back surgery?
____ History of back, arm or leg problems following surgery, injury or fracture?
____ History of high blood pressure or take medications to control blood pressure?
____ History of heart attacks?
____ History of ear or sinus surgery?
____ History of problems equalizing (popping) ears with airplane or mountain travel?
____ History of any type of hernia?
____ History of colostomy?

HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE…

____ Asthma or wheezing with breathing or wheezing with exercise?
____ Frequent colds, sinusitis, or bronchitis?
____ Pneumothorax (collapsed lung)?
____ Frequent or severe attacks of hayfever or allergy?
____ Any form of lung disease?

I HAVE READ THIS AGREEMENT, I UNDERSTAND IT, I AGREE TO BE BOUND BY IT.

____________________________________ Date:________________________________
Signature of Participant

____________________________________ ____________________________________
Witness Signature Witness Name (Print)

____________________________________ ____________________________________
Witness Address City, State, Zip

____
Telephone Number

SIGNATURE OF PARENT(S) OR GUARDIAN(S) IF PARTICIPANT IS A MINOR, and by their signature they, on my behalf release all claims that both they and I may have.

__________________________________ Date:____________________________
(Parent signature if Participant is a minor)

__________________________________ Date:____________________________
(Parent signature if Participant is a Minor)

EVENT RERESENTATIVE CONFIRMATION: I HAVE REVIEWED THIS AGREEMENT AND CONFIRM THAT IT HAS BEEN PROPERLY COMPLETED.

Signature of Event Representative:____Date_____________