Federation of Underwater Activities of Malta

Medical Statement

The purpose of this medical statement is to inform you whether you should be examined by a physician before participating in recreational scuba diving training and activities. If any of these conditions apply to you this does not necessarily disqualify you from recreational diving, but, for your own safety you must consult a physician prior to participating in recreational scuba diving activities. If in doubt, you must always seek the advice of a physician. Please fill in 'YES' if the statement has applied and/or applies to you or 'NO' if the statement has never and/or does not apply to you. **(This Medical Statement is not applicable to sport diving instructors).**

Personal data provided here is processed as per FUAM's Privacy Notice, a copy of which is available on the FUAM website: www.fuam.org.mt

Please tick Yes or No

Are you?	**YES**	**NO**
• Pregnant or you suspect you may be pregnant	☐	☐
• Regularly take medication (with the exception of birth control).	☐	☐
• Over 45 years of age and you smoke	☐	☐
• Over 45 years of age and you have a high cholesterol level	☐	☐
Did you ever have?	**YES**	**NO**
• Asthma, or wheezing with breathing or wheezing with exercise	☐	☐
• Any form of lung disease	☐	☐
• Pneumathorax (collapsed lung)	☐	☐
• History of chest surgery	☐	☐
• Claustrophobia or agoraphobia (fear of closed or open spaces)	☐	☐
• Epilepsy, seizures, convulsions or take medications to prevent them	☐	☐
• History of head injury or blackouts or fainting (full/partial loss of consciousness)	☐	☐
• History of serious disability/injury	☐	☐
• History of diving accidents or decompression sickness	☐	☐
• History of diabetes	☐	☐
• History of high blood pressure or take medication to control blood pressure	☐	☐
• History of any heart disease	☐	☐
• History of ear disease, hearing loss or problems with balance	☐	☐
• History of thrombosis or blood clotting	☐	☐
• Psychiatric diseases		

Customer Declaration

I am aware that I could be unfit to dive if I currently have or develop any of the following conditions	INITIALS
• Cold, sinusitis, or any breathing problems (e.g. bronchitis, hay fever)	
• Acute migraine or headache	
• Any kind of surgery within the last six weeks	
• Under influence of alcohol, drugs or medications effecting the ability to react	
• Fever, dizziness, nausea, vomiting and diarrhoea	
• Problems equalising (popping ears)	
• Acute gastric ulcers	
• Pregnancy or suspected pregnancy	

- **I confirm that the answers to the above statements are accurate to the best of my knowledge.**
- **I accept full responsibility for failing to disclose any past or existing medical condition/s.**
- **I accept full responsibility to retake this Medical Statement should my medical status change or should I become unsure of the statement given during the course of my scuba diving activities.**
- **If any of these conditions apply to you, the medical certificate at the back must be completed by a physician.**
- **This declaration is otherwise valid for one year from date of signature.**

☐ **Tick this box to confirm that you consent to FUAM to process your health data in terms of the privacy notice available on www.fuam.org.mt**

Name: _____ Date of Birth: (dd/mm/yy) _____

Address: _____ ID Card Nº/ Passport Nº: _____

_____

Signature: _____ Date: _____

Parental/Guardian consent needed where participant is a minor

Name of Parent/Guardian* _____
(Delete as applicable)

Address: _____ ID Card Nº/ Passport Nº: _____

_____

Signature: _____ Date: _____