

LIABILITY RELEASE AND ASSUMPTION OF RISK AGREEMENT

I, _____, hereby affirm that I am aware that skin and scuba diving have inherent risks which may result in serious injury or death. I understand that diving with compressed air involves certain inherent risks; including but not limited to decompression sickness, embolism or other hyperbaric/air expansion injury that require treatment in a recompression chamber. I further understand that the open water diving trips 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 dives in spite of the possible absence of a recompression chamber in proximity to the dive site.

I understand this Liability Release and Assumption of Risk Agreement (Agreement) hereby encompasses and applies to all diver training activities and courses in which I choose to participate. These activities and courses may include, but are not limited to, altitude, boat, cavern, AWARE, deep, enriched air, photography/videography, diver propulsion vehicle, drift, dry suit, ice, multilevel, night, peak performance buoyancy, search & recovery, rebreather, underwater naturalist, navigator, wreck, adventure diver, rescue diver and other distinctive specialties (hereinafter "Programs").

I understand and agree that neither my instructor(s), divemasters(s), the facility which provides the Programs

Hampton Dive Center nor PADI Americas, Inc., nor its affiliate and subsidiary corporations, nor any of their respective employees, officers, agents, contractors or assigns (hereinafter referred to as "Released Parties") may be held liable or responsible in any way for any injury, death or other damages to me, my family, estate, heirs or assigns that may occur as a result of my participation in the Programs or as a result of the negligence of any party, including the Released Parties, whether passive or active.

In consideration of being allowed to participate in the Programs, I hereby personally assume all risks of the Programs, whether foreseen or unforeseen, that may befall me while I am a participant in the Programs including, but not limited to, the academics, confined water and/or open water activities. I further release, exempt and hold harmless said Programs and Released Parties from any claim or lawsuit by me, my family,

estate, heirs or assigns, arising out of my enrollment and participation in this program including both claims arising during the program or after I receive my certification(s).

I understand that past or present medical conditions may be contraindicative to my participation in the Programs. I declare that I am in good mental and physical fitness for diving, and that I am not under the influence of alcohol, nor am I under the influence of any drugs that are contraindicated to diving. If I am taking medication, I declare that I have seen a physician and have approval to dive while under the influence of the medication/drugs. I affirm it is my responsibility to inform my instructor of any and all changes to my health condition at any time during my participation in the Programs and agree to accept responsibility for my failure to do so.

I also understand that skin diving and scuba diving are physically strenuous activities and that I will be exerting myself during this program, and that if I am injured as a result of heart attack, panic, hyperventilation, drowning or any other cause, that I expressly assume the risk of said injuries and that I will not hold the Released Parties responsible for the same.

I further state that I am of lawful age and legally competent to sign this Liability Release and Assumption of Risk Agreement, or that I have acquired the written consent of my parent or guardian. I understand the terms herein are contractual and not a mere recital, and that I have signed this Agreement of my own free act and with the knowledge that I hereby agree to waive my legal rights. I further agree that if any provision of this Agreement is found to be unenforceable or invalid, that provision shall be severed from this Agreement. The remainder of this Agreement will then be construed as though the unenforceable provision had never been contained herein.

I hereby state and agree this Agreement will be effective for all activities associated with the Programs in which I participate within one year from the date on which I sign this Agreement.

I understand and agree that I am not only giving up my right to sue the Released Parties but also any rights my heirs, assigns, or beneficiaries may have to sue the Released Parties resulting from my death. I further represent I have the authority to do so and that my heirs, assigns, or beneficiaries will be estopped from claiming otherwise because of my representations to the Released Parties.

I, _____, HAVE COMPLETED THE ATTACHED DIVER MEDICAL FORM (10346) AND I AFFIRM IT IS MY RESPONSIBILITY TO INFORM MY INSTRUCTOR OF ANY AND ALL CHANGES TO MEDICAL HISTORY AT ANY TIME DURING MY PARTICIPATION IN SCUBA PROGRAMS. I AGREE TO ACCEPT RESPONSIBILITY FOR OMISSIONS REGARDING MY FAILURE TO DISCLOSE ANY EXISTING OR PAST HEALTH CONDITION, OR ANY CHANGES THERETO.

I, _____, BY THIS INSTRUMENT AGREE TO EXEMPT AND RELEASE MY INSTRUCTORS, DIVEMASTERS, THE FACILITY WHICH OFFERS THE PROGRAMS AND PADI AMERICAS, INC., AND ALL RELATED ENTITIES AND RELEASED PARTIES 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 NON-AGENCY DISCLOSURE AND ACKNOWLEDGMENT AGREEMENT, LIABILITY RELEASE AND ASSUMPTION OF RISK AGREEMENT, DIVER MEDICAL AND STANDARD SAFE DIVING PRACTICES STATEMENT OF UNDERSTANDING BY READING THEM BEFORE SIGNING BELOW ON BEHALF OF MYSELF AND MY HEIRS.

Participant's Signature

Date (Day/Month/Year)

Signature of Parent or Guardian (where applicable)

Date (Day/Month/Year)



Diver Medical | Participant Questionnaire

Recreational scuba diving and freediving requires good physical and mental health. There are a few medical conditions which can be hazardous while diving, listed below. Those who have, or are predisposed to, any of these conditions, should be evaluated by a physician. This Diver Medical Participant Questionnaire provides a basis to determine if you should seek out that evaluation. If you have any concerns about your diving fitness not represented on this form, consult with your physician before diving. If you are feeling ill, avoid diving. If you think you may have a contagious disease, protect yourself and others by not participating in dive training and/or dive activities. References to "diving" on this form encompass both recreational scuba diving and freediving. This form is principally designed as an initial medical screen for new divers, but is also appropriate for divers taking continuing education. For your safety, and that of others who may dive with you, answer all questions honestly.

Directions

Complete this questionnaire as a prerequisite to a recreational scuba diving or freediving course.

Note to women: If you are pregnant, or attempting to become pregnant, *do not dive*.

1	I have had problems with my lungs, breathing, heart and/or blood affecting my normal physical or mental performance.	Yes <input type="checkbox"/> Go to box A	No <input type="checkbox"/>
2	I am over 45 years of age.	Yes <input type="checkbox"/> Go to box B	No <input type="checkbox"/>
3	I struggle to perform moderate exercise (for example, walk 1.6 kilometer/one mile in 14 minutes or swim 200 meters/yards without resting), OR I have been unable to participate in a normal physical activity due to fitness or health reasons within the past 12 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
4	I have had problems with my eyes, ears, or nasal passages/sinuses.	Yes <input type="checkbox"/> Go to box C	No <input type="checkbox"/>
5	I have had surgery within the last 12 months, OR I have ongoing problems related to past surgery.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
6	I have lost consciousness, had migraine headaches, seizures, stroke, significant head injury, or suffer from persistent neurologic injury or disease.	Yes <input type="checkbox"/> Go to box D	No <input type="checkbox"/>
7	I am currently undergoing treatment (or have required treatment within the last five years) for psychological problems, personality disorder, panic attacks, or an addiction to drugs or alcohol; or, I have been diagnosed with a learning or developmental disability.	Yes <input type="checkbox"/> Go to box E	No <input type="checkbox"/>
8	I have had back problems, hernia, ulcers, or diabetes.	Yes <input type="checkbox"/> Go to box F	No <input type="checkbox"/>
9	I have had stomach or intestine problems, including recent diarrhea.	Yes <input type="checkbox"/> Go to box G	No <input type="checkbox"/>
10	I am taking prescription medications (with the exception of birth control or or anti-malarial drugs other than mefloquine (Lariam).	Yes <input type="checkbox"/> *	No <input type="checkbox"/>

Participant Signature

If you answered **NO** to all 10 questions above, a medical evaluation is not required. Please read and agree to the participant statement below by signing and dating it.

Participant Statement: I have answered all questions honestly, and understand that I accept responsibility for any consequences resulting from any questions I may have answered inaccurately or for my failure to disclose any existing or past health conditions.

Participant Signature (or, if a minor, participant's parent/guardian signature required.)

Date (dd/mm/yyyy)

Participant Name (Print)

Birthdate (dd/mm/yyyy)

HAMPTON DIVE CRTR. STAFF

Hampton Dive Center

Instructor Name (Print)

Facility Name (Print)

* If you answered **YES** to questions 3, 5 or 10 above **OR** to any of the questions on page 2, please read and agree to the statement above by signing and dating it **AND take all three pages of this form (Participant Questionnaire and the Physician's Evaluation Form) to your physician** for a medical evaluation. Participation in a diving course requires your physician's approval.

Participant Name

Birthdate

(Print)

Date (dd/mm/yyyy)

Diver Medical | Participant Questionnaire Continued

BOX A – I HAVE/HAVE HAD:		
Chest surgery, heart surgery, heart valve surgery, an implantable medical device (eg, stent, pacemaker, neurostimulator), pneumothorax, and/or chronic lung disease	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Asthma, wheezing, severe allergies, hay fever or congested airways within the last 12 months that limits my physical activity/exercise.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
A problem or illness involving my heart such as: angina, chest pain on exertion, heart failure, immersion pulmonary edema, heart attack or stroke. OR am taking medication for any heart condition.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Recurrent bronchitis and currently coughing within the past 12 months. OR have been diagnosed with emphysema	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Symptoms affecting my lungs, breathing, heart and/or blood in the last 30 days that impair my physical or mental performance.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
BOX B – I AM OVER 45 YEARS OF AGE AND:		
I currently smoke or inhale nicotine by other means.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
I have a high cholesterol level.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
I have high blood pressure.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
I have had a close blood relative die suddenly or of cardiac disease or stroke before the age of 50, OR have a family history of heart disease before age 50 (including abnormal heart rhythms, coronary artery disease or cardiomyopathy)	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
BOX C – I HAVE/HAVE HAD:		
Sinus surgery within the last 6 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Ear disease or ear surgery, hearing loss, or problems with balance.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Recurrent sinusitis within the past 12 months	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Eye surgery within the past 3 months	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
BOX D – I HAVE/HAVE HAD:		
Head injury with loss of consciousness within the past 5 years	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Persistent neurologic injury or disease.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Recurring migraine headaches within the past 12 months, or take medications to prevent them.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Blackouts or fainting (full/partial loss of consciousness) within the last 5 years.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Epilepsy, seizures, or convulsions, OR take medications to prevent them	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
BOX E – I HAVE/HAVE HAD:		
Behavioral health, mental or psychological problems requiring medical/psychiatric treatment.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Major depression, suicidal ideation, panic attacks, uncontrolled bipolar disorder requiring medication/psychiatric treatment	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Been diagnosed with a mental health condition or a learning/developmental disorder that requires ongoing care or special accommodation.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
An addiction to drugs or alcohol requiring treatment within the last 5 years.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
BOX F – I HAVE/HAVE HAD:		
Recurrent back problems in the last 6 months that limit my everyday activity	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Back or spinal surgery within the last 12 months	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Diabetes, either drug or diet controlled, OR gestational diabetes within the last 12 months	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
An uncorrected hernia that limits my physical abilities	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Active or untreated ulcers, problem wounds, or ulcer surgery within the last 6 months	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
BOX G – I HAVE HAD:		
Ostomy surgery and do not have medical clearance to swim or engage in physical activity	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Dehydration requiring medical intervention within the last 7 days	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Active or untreated stomach or intestinal ulcers or ulcer surgery within the last 6 months	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Frequent heartburn, regurgitation, or gastroesophageal reflux disease (GERD)	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Active or uncontrolled ulcerative colitis or Crohn's disease.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Bariatric surgery within the last 12 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>