

Student Info:

Personal and Confidential

Print Clearly



Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Last / Family / Surname First / Given Initial Day / Month / Year

Address: \_\_\_\_\_

M  F  
 Single  
 Married

City: \_\_\_\_\_ State/Province: \_\_\_\_\_

Zip/Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Referred by: \_\_\_\_\_

Emergency Contact:



Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work/Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work/Cell Phone: \_\_\_\_\_



How did you hear about our scuba courses or our dive center?

- Friend/Family member
- Internet
- Radio
- Newspaper
- Yellow Pages
- Other \_\_\_\_\_

Have you ever participated in any diving activities?

Where? \_\_\_\_\_

When? \_\_\_\_\_

What additional SDI courses interest you?

- Advanced Diver
- Rescue Diver
- Master Scuba Diver
- Divemaster
- Assistant Instructor
- Instructor
- Advanced Adventure Diver
- Advanced Buoyancy
- Altitude Diver
- Boat Diver
- Computer Diver
- Computer Nitrox Diver
- Deep Diver
- Drift Diver
- DPV Diver
- Dry Suit Diver
- Equipment Specialist
- Full Face Mask Diver
- Ice Diver
- Marine Ecosystems Awareness
- Night/ Limited Visibility Diver
- Research Diver
- Search & Recovery Diver
- Shore/Beach Diver
- Solo Diver
- Underwater Hunter & Collector



What dive destinations interest you?

- Australia
- Bahamas
- Bermuda
- Canada
- Caribbean
- Florida
- Hawaii
- Mexico
- Micronesia
- New Zealand
- Red Sea
- US East Coast
- US West Coast
- Other \_\_\_\_\_



Diver Training Record

Course: \_\_\_\_\_

Certificate Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day / Month / Year

Instructor Name \_\_\_\_\_ SDI Inst # \_\_\_\_\_

Course: \_\_\_\_\_

Certificate Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day / Month / Year

Instructor Name \_\_\_\_\_ SDI Inst # \_\_\_\_\_

Course: \_\_\_\_\_

Certificate Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day / Month / Year

Instructor Name \_\_\_\_\_ SDI Inst # \_\_\_\_\_

Course: \_\_\_\_\_

Certificate Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day / Month / Year

Instructor Name \_\_\_\_\_ SDI Inst # \_\_\_\_\_

Course: \_\_\_\_\_

Certificate Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day / Month / Year

Instructor Name \_\_\_\_\_ SDI Inst # \_\_\_\_\_

Course: \_\_\_\_\_

Certificate Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day / Month / Year

Instructor Name \_\_\_\_\_ SDI Inst # \_\_\_\_\_

Course: \_\_\_\_\_

Certificate Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day / Month / Year

Instructor Name \_\_\_\_\_ SDI Inst # \_\_\_\_\_

# SDI Open Water Diver Record and Global Referral Form

Student Info

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Country: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Sex: \_\_\_ M \_\_\_ F Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day / Month / Year

Academic Sessions

	Knowledge Review Completed (dd/mm/yy)	Student Initials	Instructor Initials	Comments
Chapter 1	___/___/___	_____	_____	
Chapter 2	___/___/___	_____	_____	
Chapter 3	___/___/___	_____	_____	
Chapter 4	___/___/___	_____	_____	
Chapter 5	___/___/___	_____	_____	

**-OR-**  This student completed the SDI eLearning course: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day / Month / Year

Confined Water Sessions

	Date Completed (dd/mm/yy)	Student Initials	Instructor Initials	Comments
CW Session 1	___/___/___	_____	_____	
CW Session 2	___/___/___	_____	_____	
CW Session 3	___/___/___	_____	_____	
CW Session 4	___/___/___	_____	_____	
<b>CW Session 5*</b>	___/___/___	_____	_____	<b>(*Optional)</b>
Swim Test 200 meters or 300 meters snorkel	___/___/___	_____	_____	
Float Test 10 Minute Survival Float	___/___/___	_____	_____	

Instructor 1

**Confined Water/ Academic Instructor** Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day / Month / Year  
 Instructor Name: \_\_\_\_\_  
 Instr. # \_\_\_\_\_ Facility Name: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax or E-mail: \_\_\_\_\_  
**The student above has completed all the Academic and Confined Water requirements.**  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day / Month / Year

Open Water Sessions

## Open Water / Evaluating Instructor MUST:

- \_\_\_ Be an **Active Instructor** with an internationally recognized training agency.
- \_\_\_ Review students' medical history form.
- \_\_\_ Have referring student sign your facility's waiver and release form.
- \_\_\_ Evaluate **and** Initial all the required open water skill and dives listed on this form.
- \_\_\_ Sign this global referral form.
- \_\_\_ Give this original referral form to the student, and retain a copy of this form for your records.

## Skill Performance Record for the Global Referral:

	Date Completed (dd/mm/yy)	Student Initials	Instructor Initials	Comments
<b>Scuba System</b>				
___ Assembly & Disassembly				
<b>Pre Dive Check</b>				
___ Self & Buddy				
___ Underwater Communication				
<b>Computer Use</b>				
___ Reading & Understanding Gauges				
<b>Regulator Use</b>				
___ Clearing & Recovery				
<b>Mask Clear</b>				
___ Partial & Full				
<b>BCD</b>				
___ Auto & Oral Inflation				
<b>Entries</b>				
___ Demonstrate 2 types of entries				
<b>Buoyancy Control</b>				
___ Fin Pivot				
___ Hovering				
___ Controlled Ascents				
___ Controlled Descents				
<b>Weight System Adjustment</b>				
___ Removal & Replacement				
<b>Out of Air Emergencies</b>				
___ Alternate Air Source				
___ Share Air with Buddy while making a controlled ascent				
___ Swimming Ascent				
<b>Rescue Techniques</b>				
___ Tired Diver Tow				
___ Cramp Relief				

Instructor 2

**Open Water/ Evaluating Instructor** Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day / Month / Year  
 Instructor Name: \_\_\_\_\_ Instr. # \_\_\_\_\_  
 Training Agency: \_\_\_\_\_ Facility Name: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax or E-mail: \_\_\_\_\_  
**The student above has completed all the Skills and Open Water requirements.**  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day / Month / Year

All requirements for certification as a SDI Open Water Scuba Diver have been met - If **BOTH INSTRUCTOR SIGNATURES ARE PRESENT ON THIS FORM** The student is considered a certified open water diver. This signed form is only **VALID FOR 30 DAYS** from the last OW dive that the evaluating instructor signed and dated. This is only a temporary open water certification card until the diver receives their permanent open water c-card.

**STUDENT LETTER OF AGREEMENT:** The student agrees that all of the academic, confined and open water requirements for this SDI diver course have been successfully fulfilled by the student. As indicated by the signature below, the student is mentally and physically prepared to engage in open water diving activities without the direct supervision of an instructor, provided the area and conditions approximate those in which the diver was trained. In addition, the student recognizes the need for additional training in order to dive under any other circumstances and after periods of diving inactivity.

**STUDENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day / Month / Year



# GENERAL LIABILITY RELEASE AND EXPRESS ASSUMPTION OF RISK

For \_\_\_\_\_ (specify course) training program under sanction through SDI.

**(Only ONE course can be listed on this form)**

**Please read carefully. If any questions arise, ask your instructor before signing.  
Fill in and initial each paragraph before signing at the bottom.**

I, \_\_\_\_\_, hereby affirm that I have been advised and thoroughly informed of the inherent hazards of scuba diving activities

INITIALS REQUIRED

\_\_\_\_\_ Further, I understand that diving with compressed air, oxygen enriched air (nitrox) involves certain inherent risks including decompression sickness, embolism, oxygen toxicity, inert gas narcosis, marine life injuries or other barotrauma/hyper baric injuries can occur that require treatment in a recompression chamber. I further understand that the open water diving trips, which are necessary for training and certification, may be conducted at a site that is remote, either by time of distance or both, from such a recompression chamber. I still choose to proceed with such instructional dives in spite of the possible absence of a recompression chamber in proximity to the dive site.

INITIALS REQUIRED

\_\_\_\_\_ I understand and agree that neither my instructor(s) \_\_\_\_\_, the facility through which I received my instruction, \_\_\_\_\_ Dive Spear and Sport International Training and Scuba Diving International, nor the officers, directors, shareholders, affiliated companies, employees, agents, or assigns of the above listed entities and/or individuals, nor the authors of any materials including texts and tables expressly used for training and certification (hereinafter referred to as "Released Parties") may be held liable or responsible in anyway for any injury, death, or other damages to me or my family, heirs, or assigns that may occur as a result of my participation in this diving class or as a result of the negligence of any party, including the Released Parties, whether passive or active.

INITIALS REQUIRED

\_\_\_\_\_ In consideration of being allowed to enroll in this course, I hereby personally assume all risks in connection with said course, for any harm, injury, or damage that may befall me while I am enrolled as a student of this course, including all risks connected therewith, whether foreseen or unforeseen.

INITIALS REQUIRED

\_\_\_\_\_ I further agree to save, defend, indemnify, and hold harmless said course and Released Parties from any claim or lawsuit by me, anyone purporting to act on my behalf, my family, estate, heirs or assigns, arising directly or indirectly out of my enrollment and participation in this course including both claims arising during the course or after I receive my certification even if such claims may be groundless, false or fraudulent.

INITIALS REQUIRED

\_\_\_\_\_ I also understand that diving activities are physically strenuous and that I will be exerting myself during this diving course, and that if I am injured as a result of heart attack, panic, hyperventilation, oxygen toxicity, inert gas narcosis, drowning, etc. that I expressly assume the risk of said injuries and that I will not hold the above listed individuals or companies responsible for the same, and I agree to defend, indemnify, and hold harmless said course and Released Parties for any such injuries incurred by me.

INITIALS REQUIRED

\_\_\_\_\_ I understand that these activities may place me deeper than I am able to safely execute a free (without breathing gas) ascent from.

INITIALS REQUIRED

\_\_\_\_\_ I understand that I may be required to furnish my own equipment and that I am responsible for its operating condition and maintenance.

INITIALS REQUIRED

\_\_\_\_\_ I further state that I am of lawful age and legally competent to sign this liability release, or that I have acquired the written consent of my parent or guardian.

INITIALS REQUIRED

\_\_\_\_\_ I understand that the terms herein are contractual and not a mere recital, and that I have signed this document of my own free act. Further that I understand and agree that, in the event that one or more of the provisions of this agreement, for any reason, is held by a court of competent jurisdiction to be invalid or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provision hereof, and this agreement shall be construed as if such invalid, illegal or unenforceable provision or provisions had never been contained herein.

IT IS THE INTENTION OF \_\_\_\_\_ BY THIS INSTRUMENT TO EXEMPT AND RELEASE MY INSTRUCTORS, \_\_\_\_\_ (AND OTHERS, \_\_\_\_\_), THE FACILITY THROUGH WHICH I RECEIVED MY INSTRUCTION \_\_\_\_\_ Dive Spear and Sport, THE TRAINING AGENCY \_\_\_\_\_ SDI \_\_\_\_\_ AND INTERNATIONAL TRAINING, AND SCUBA DIVING INTERNATIONAL, AND ALL OTHER RELATED ENTITIES AND RELEASED PARTIES AS DEFINED ABOVE, FROM ALL LIABILITY OR RESPONSIBILITY WHATSOEVER FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH HOWEVER CAUSED, OR ARISING OUT OF, DIRECTLY OR INDIRECTLY, 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 LIABILITY RELEASE AND EXPRESS ASSUMPTION OF RISK BY READING IT BEFORE SIGNING IT ON BEHALF OF MYSELF AND MY HEIRS.

\_\_\_\_\_  
Signature of Student/Participant

\_\_\_\_\_  
Date Day / Month / Year

\_\_\_\_\_  
Signature of Parent or Guardian  
(where applicable)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date Day / Month / Year

This document is required for all courses taught under sanction by Scuba Diving International.  
No alterations, changes, omissions or revisions may be made.  
Contact: Scuba Diving Int'l • 1321 SE Decker Ave., Stuart, FL 34994 • 888.778.9073 phone • 877.436.7096 fax  
worldhq@tdisdi.com tdisdi.com

# 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.

## 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.)

\_\_\_\_\_  
Participant Name (Print)

\_\_\_\_\_  
Instructor Name (Print)

\_\_\_\_\_  
Date (dd/mm/yyyy)

\_\_\_\_\_  
Birthdate (dd/mm/yyyy)

**Dive Spear and Sport**  
\_\_\_\_\_  
Facility Name (Print)

\* If you answered **YES** to questions 3, 5 or 10 above **OR** to any of the questions in boxes A - G below, 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.

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"/>

## 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 anti-malarial drugs other than mefloquine (Lariam).	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, 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"/>



Name  
(Print)  
Last / Family / Surname  
First / Given  
Initial

Daytime Phone

Cell Phone