Liability Release and Assumption of Risk Agreement

I (participant name), _____, hereby affirm that I am aware that scuba dive training in a recreation pool has inherent risks which may result in serious injury.

The information I have provided about my medical history on the Medical Questionnaire is accurate to the best of my knowledge. I agree to accept responsibility for omissions regarding my failure to disclose any existing or past health conditions.

I understand and agree that neither the dive professionals conducting this program, nor the Williams H. Williams Indoor Pool which this program is offered, Texas Scuba Adventures, Tri-Tex Scuba, nor any of their respective employees, divers, instructors, supervisors, agents 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 this program or as a result of the negligence of the Released Parties, whether passive or active.

In consideration of being allowed to participate in this program, I hereby personally assume all risks for any harm, injury or damage, whether foreseen or unforeseen, that may befall me while participating in this confined water program.

I further understand that scuba diving is a physically strenuous activity and that I expressly assume the risk of injury and that I will not hold the Released Parties responsible.

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 (participant name), _____, by this instrument do exempt and release the dive professionals conducting this program, the facility through which the program is conducted, 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 release parties, whether passive or active.

I have fully informed myself of the contents of this liability release and assumption of risk agreement by reading both before signing below on behalf of myself and my heirs and affirm the medical questionnaire is accurate.

_____ _____

Participant Signature *Date (Day/Month/Year)*

_____ _____

Parent/Guardian Signature *Date (Day/Month/Year)*

Medical Questionnaire

The purpose of this Medical Questionnaire is to find out if you should be examined by your doctor before participating in our recreational scuba activity. A positive response to a question does not necessarily disqualify you from diving. A positive response means that there is a preexisting condition that may affect your safety while diving and you must seek the advice of your physician prior to engaging in dive activities. 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 the scuba diving activity. The Space Center University Coordinator will supply you with an RSTC Medical Statement and Guidelines for Recreational Scuba Diver's Physical Examination to take to your physician.

☐ Could you be pregnant, or are you attempting to become pregnant?
☐ Are you presently taking prescription medications? (with the exception of birth control or anti-malarial)
☐ Are you over 45 years of age and can answer YES to one or more of the following? • currently smoke a pipe, cigars or cigarettes • have a high cholesterol level • have a family history of heart attack or stroke • are currently receiving medical care • high blood pressure • diabetes mellitus, even if controlled by diet alone

Have you ever had or do you currently have…

☐ Asthma, or wheezing with breathing, or wheezing with exercise?
☐ Frequent or severe attacks of hay fever or allergy?
☐ Frequent colds, sinusitis or bronchitis?
☐ Any form of lung disease?
☐ Pneumothorax (collapsed lung)?
☐ Other chest disease or chest surgery?
☐ Behavioral health, mental or psychological problems (Panic attack, fear of closed or open spaces)?
☐ Epilepsy, seizures, convulsions or take medications to prevent them?
☐ Recurring complicated migraine headaches or take medications to prevent them?
☐ Blackouts or fainting (full/partial loss of consciousness)?
☐ Frequent or severe suffering from motion sickness (seasick, carsick, etc.)?
☐ Dysentery or dehydration requiring medical intervention?
☐ Any dive accidents or decompression sickness?
☐ Inability to perform moderate exercise (example: walk 1.6 km/one mile within 12 mins.)?
☐ Head injury with loss of consciousness in the past five years?
☐ Back or spinal surgery?
☐ Diabetes?
☐ Back, arm or leg problems following surgery, injury or fracture?
☐ High blood pressure or take medicine to control blood pressure?
☐ Heart disease?
☐ Heart attack?
☐ Angina, heart surgery or blood vessel surgery?
☐ Sinus surgery?
☐ Ear disease or surgery, hearing loss or problems with balance?
☐ Recurrent ear problems?
☐ Bleeding or other blood disorders?
☐ Hernia?
☐ Ulcers or ulcer surgery?

The information I have provided about my medical history is accurate to the best of my knowledge. I agree to accept responsibility for omissions regarding my failure to disclose any existing or past health condition.

Participant Signature | *Date (Day/Month/Year)*

Parent/Guardian Signature | *Date (Day/Month/Year)*