



CSAC
Calypso Sub-Aqua Club BSAC 393 Malta



Calypso Sub-Aqua Club
c/o Dive Systems (W.S.) Ltd.
Tower Point, Tower Road, Exiles
Sliema SLM 1601,
MALTA
E-mail: info@calypsosac.org
Website: www.calypsosac.org

Enrolment Form

Personal Information: (PLEASE PRINT CLEARLY)

Name:

Surname:

Address:

Town:

Post Code:

Date of Birth:

Contact Telephone No:

Emergency Contact Telephone No. & Name / Relationship :

E-mail address:

Diving Qualification :

BSAC

PADI

CMAS

SAA

Other:

I agree to abide by the rules of the Calypso Sub-Aqua Club and acknowledge that I undertake underwater swimming and associated activities at my own risk and responsibility. I am not suffering from any physical complaint or ailment which may jeopardize my safety or wellbeing whilst taking part in such activities and agree that the Calypso Sub-Aqua Club may hold my Membership details on a computer database.

Signature:

Date:

Signature of Parent/Guardian if under 18 :

Membership Receipt :

Received the amount of €25.00 in respect of 12 months subscription.

Treasurer:

Date:

Please turn over for Medical Statement Form

Medical Statement (PLEASE PRINT CLEARLY) - As per Laws of Malta - S.L.409.13

You must complete this medical statement, which includes the medical history information section, prior to enjoying any recreational scuba diving services. Its purpose is to inform you whether you should be examined by a physician before participating in recreational diving training. If any of these conditions apply to you, this does **not** necessarily disqualify you. It only means that, for your own **safety**, you must seek the advice of a physician prior to participating in recreational scuba diving. Please acknowledge that you have read and understood the information provided below by initialling each individual point. **With your signature at the end, you confirm that the answers to the questions above are true and complete.**

<u>1. YOU MUST CONSULT A PHYSICIAN IF</u>	YES or NO	INITIALS	
You are pregnant or you suspect you may be pregnant			
You regularly take medications (with the exception of birth control)			
You are over 45 years of age and one or more of the following apply: <ul style="list-style-type: none"> • You smoke • You have a high cholesterol level 			
<u>2. YOU MUST CONSULT A PHYSICIAN IF YOU EVER HAD</u>	YES or NO	INITIALS	
asthma, or wheezing with breathing or wheezing with exercise			
any form of lung disease			
pneumothorax (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 blackouts or fainting (full or partial loss of consciousness)			
history of diving accidents or decompression sickness			
history of diabetes			
history of high blood pressure or take medications to control blood pressure			
history of heart disease			
history of ear disease, hearing loss or problems with balance			
history of thrombosis or blood clotting			
psychiatric disease			
<u>3. I AM AWARE I COULD BE UNFIT TO DIVE IF I HAVE OR DEVELOP ANY ONE OF THE FOLLOWING CONDITIONS</u>	INITIALS		
Cold, sinusitis, or any breathing problems such as bronchitis and hay fever			
Acute migraine or headache			
Any kind of surgery within the last six weeks			
Under influence of alcohol, drugs or medication affecting the ability to react			
Fever, dizziness, nausea, vomiting and diarrhoea			
Problems equalising such as when popping ears			
Pregnancy and/or Acute gastric ulcers			
Name:	Surname:	Date of Birth:	Signature