



## Adaptive Diver Registry Form

To Be Completed By The Adaptive Diver, Parent, or Guardian

ADAPTIVE DIVER INFORMATION										
First Name:			Last Name:			M.I.		Birthdate: mm/dd/yyyy		
Weight: lbs.		Height: ft/in		Shoe Size:	Tshirt Size:		<input type="checkbox"/> Married <input type="checkbox"/> Single	Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
Email:						Phone:				
Address:										
City:			State/Province:			Country:		Zip Code:		
Military Affiliation: <input type="checkbox"/> None <input type="checkbox"/> Active <input type="checkbox"/> Veteran <input type="checkbox"/> Retired				Branch:		Purple Heart Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Ethnicity:			How Did You Hear About Diveheart?							
EMERGENCY CONTACT INFORMATION										
Name:						Relationship:				
Email:						Mobil#:				
Address:										
City:			State/Province:			Country:		Zip Code:		
MEDICAL HISTORY										
1) Describe your general health and any medical condition which impacts, to any extent, your activities of daily living and/or which you believe may affect your ability to SCUBA dive. Date of initial onset of such medical condition: _____										
2) Describe specifically any physical impairment you may have:										
3) Describe specifically any cognitive, psychological and/ or emotional impairment you may have:										
4) Do you have any indwelling medical devices in your body? <input type="checkbox"/> Baclofen pump <input type="checkbox"/> Insulin pump <input type="checkbox"/> Pacemaker <input type="checkbox"/> No										
5) Do you currently have any open skin wounds? <input type="checkbox"/> Yes <input type="checkbox"/> No										
6) Have you ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No						Date of last seizure:				
7) Are you on any anti-seizure medication? <input type="checkbox"/> Yes <input type="checkbox"/> No										
8) Have you ever suffered from autonomic dysreflexia? <input type="checkbox"/> Yes <input type="checkbox"/> No										
9) Hearing: <input type="checkbox"/> deaf <input type="checkbox"/> hard of hearing <input type="checkbox"/> hearing aid <input type="checkbox"/> N/A										
10) Vision: <input type="checkbox"/> blind <input type="checkbox"/> visually impaired <input type="checkbox"/> glasses <input type="checkbox"/> contacts <input type="checkbox"/> N/A										
11) Do you use any medical devices related to your condition?(Check all that apply)										
<input type="checkbox"/> Walking cane			<input type="checkbox"/> Walker		<input type="checkbox"/> Wheelchair		<input type="checkbox"/> Drainage Bag(s)		Prosthetic/Brace: <input type="checkbox"/> L arm <input type="checkbox"/> R arm <input type="checkbox"/> L leg <input type="checkbox"/> R leg	
<input type="checkbox"/> Other devices and/or supplies:										



**COGNITIVE/ PSYCHOLOGICAL INFORMATION**

**Obtain the following information from the most reliable sources available: healthcare providers, parents, guardians, friends, and identify the source of information. If any of the following apply to the adaptive diver, please expand on them in the space provided below.**

1) Triggers: If the adaptive diver has any type of cognitive, psychological, or emotional impairment, please describe what, if anything, upsets or disturbs the individual or causes other emotional stress.

2) Tactile Sensitivity: Is the adaptive diver sensitive to anything touching them? If so, please describe.

3) What calming techniques are most effective should the adaptive diver become emotionally disturbed or upset? (e.g., diverting attention to favored topics, etc.)

Empty lines for providing answers to questions 1, 2, and 3.

4) Is there a health care provider, parent, guardian, friend, or other individual who knows how to address situations that may trigger emotional stress in the adaptive diver? If so, please provide their contact information.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Email: \_\_\_\_\_ Phone: \_\_\_\_\_

**CURRENT MEDICATIONS / ALLERGIES**

Please list any medications you are currently taking, what they are for, dose, and administration regime. Please list any allergies.

Empty lines for listing medications and allergies.

**WATER SKILLS**

1) Can you swim and tread water?  Yes  No      2) Can you snorkel?  Yes  No

3) Have you ever participated in an Introduction to SCUBA event?  Yes  No

Location: \_\_\_\_\_ Date: \_\_\_\_\_

4) Are you a certified SCUBA diver?  Yes  No      Agency: \_\_\_\_\_      Cert Level: \_\_\_\_\_      Cert Date: \_\_\_\_\_

5) Were you a certified SCUBA diver prior to your disability or physical impairment?  Yes  No

Date of last SCUBA dive? \_\_\_\_\_ Total number of dives? \_\_\_\_\_

**VERIFICATION AND ACKNOWLEDGMENT**

**I, \_\_\_\_\_, (adaptive diver), have reviewed the above registry information and verify that all the above information is true.**

Print Full Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**I, \_\_\_\_\_, the natural parent or legal guardian of the above identified adaptive diver, have reviewed the above registry information and verify that all the above information is true.**

Print Full Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_