

Splash Water Sports  
**DISCOVER SNORKELING**  
Student Cover Form

**Student Information:**

\*First Name: \_\_\_\_\_

\*Last Name: \_\_\_\_\_

\*Birthday: \_\_\_\_\_

\*Phone Number: \_\_\_\_\_

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

**Student Checklist:**

- Payment (Groupon accepted).
- Non-Agency Disclosure.
- Medical Questionnaire.
- Doctor's Signature (if needed for Medicals).
- Photo Consent Form (optional).

Please print out the attached form and bring them into our store, or you can have them emailed to our office: [dive@splashscuba.com](mailto:dive@splashscuba.com)

**Winter Store Hours:**

Tuesday — Friday  
10:00am - 6:00pm  
Saturday  
9:00am - 5:00pm  
Sunday & Monday  
CLOSED

**Phone:**

412-531-5577

**Location:**

2905 Banksville Rd  
Pittsburgh, PA 15216



# Non-Agency Disclosure and Acknowledgement Agreement

Please read carefully and fill in all blanks before signing.

I understand and agree that PADI Members (“Members”), **SPLASH WATER SPORTS** and/or any individual PADI Instructors and Divemasters associated with the program in which I am participating, are licensed to use various PADI Trademarks and to conduct PADI training, but are not agents, employees or franchisees of PADI Americas, Inc, or its parent, subsidiary and affiliated corporations (“PADI”). I further understand that Member business activities are independent, and are neither owned nor operated by PADI, and that while PADI establishes the standards for PADI diver training programs, it is not responsible for, nor does it have the right to control, the operation of the Members’ business activities and the day-to-day conduct of PADI programs and supervision of divers by the Members of their associated staff, I further understand and agree on behalf of myself, my heirs and my estate that in the event of an injury or death during this activity, neither I nor my estate shall seek to hold PADI liable for the actions, inactions or negligence of **SPLASH WATER SPORTS** and/or the instructors and Divemasters associated with the activity.

## Liability Release and Assumption of Risk Agreement

Please read carefully and fill in all blanks before signing.

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 involved 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 instructional dives despite the possible absence of a recompression chamber in proximity to the dive site.

I understand and agree that neither my instructor(s) and the facility through which I receive my instruction, **SPLASH WATER SPORTS**, 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 this diving program or as a result of negligence of any party, including the Released Parties, whether passive or active.

In consideration of being allowed to participate in this course (and optional Adventure Dive), hereinafter referred to as “program,” I hereby personally assume all risks of this program, whether foreseen or unforeseen, that may befall me while I am a participant in this program including, but not limited to, the academics, confined water and/or open water activities.

I further release, exempt and hold harmless said program 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.

**I HAVE FULLY INFORMED MYSELF AND MY HEIRS OF THE CONTENTS OF THIS NON-AGENCY DISCLOSURE AND ACKNOWLEDGEMENT AGREEMENT AND LIABILITY RELEASE AND ASSUMPTION OF RISK AGREEMENT BY READING BOTH BEFORE SIGNING BELOW ON BEHALF OF MYSELF AND MY HEIRS.**

Participant Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_

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 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, 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 understand and agree that I am not only giving up my rights 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 representation to the Released Parties.

I, \_\_\_\_\_, BY THIS INSTRUMENT AGREE TO EXEMPT AND RELEASE MY INSTRUCTORS AND THE FACILITY THROUGH WHICH I RECEIVE MY INSTRUCTION, **SPLASH WATER SPORTS**, AND PADI AMERICAS, INC., AND ALL RELATED ENTITIES 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.



# 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, blood, or have been diagnosed with COVID-19.	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 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"/>

## 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)
_____	_____
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 \_\_\_\_\_

(Print)

Birthdate \_\_\_\_\_

Date (dd/mm/yyyy)

**Diver Medical** | Participant Questionnaire Continued**Box A – I have/have had:**

Chest surgery, heart surgery, heart valve surgery, stent placement, or a pneumothorax (collapsed lung).	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"/>
A diagnosis of COVID-19.	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.	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"/>

# Diver Medical | Physician's Evaluation Form

Participant Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
(Print) Date (dd/mm/yyyy)

The above-named person requests your opinion of his/her medical suitability to participate in recreational scuba diving or freediving training or activity. Please visit [uhms.org](http://uhms.org) for medical guidance on medical conditions as they relate to diving. Review the areas relevant to your patient as part of your evaluation.

## Evaluation Result

- Approved – I find no conditions that I consider incompatible with recreational scuba diving or freediving.  
 Not approved – I find conditions that I consider incompatible with recreational scuba diving or freediving.

\_\_\_\_\_  
Physician's Signature Date (dd/mm/yyyy)

Physician's Name \_\_\_\_\_ Specialty \_\_\_\_\_  
(Print)

Clinic/Hospital \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Physician/Clinic Stamp (optional)

Created by the [Diver Medical Screen Committee](#) in association with the following bodies:

The Undersea & Hyperbaric Medical Society  
DAN (US)  
DAN Europe  
Hyperbaric Medicine Division, University of California, San Diego

# Photography Consent Form

Splash Water Sports, Inc.

I, the undersigned, am an adult and voluntarily consent to be photographed, or I consent to having the person for which I am the legal guardian photographed (still photo, film and/or videotape/recording) by the photographer employed, engaged or other otherwise approved by Splash Water Sports, Inc. I understand that the photographs and videos are for publicity, education, advertising or public information efforts on behalf of Splash Water Sports, Inc. I authorize any such use, by or on behalf of Splash Water Sports, Inc., and I understand that I will not be paid or compensated by Splash Water Sports, Inc. in any way.

I hereby release and discharge Splash Water Sports, Inc. and its employees, agents, and representatives of any claims liability, or results caused by the lawful use of the said photograph(s) of me or the person for which I am the legal guardian, who I have now voluntarily authorized as a gift to Splash Water Sports, Inc.

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Printed Name

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Signature

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Witness (Splash Employee)

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Date

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Legal Guardian Printed Name

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Legal Guardian Signature

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Printed Name of Minor

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Date