Underwater Astronaut Trainer Release & Medical Form (Part 1 of 2)

SCIVIS - SCUBA ADVANCED SPACE ACADEMY
Dan Oates
190 Armstrong St., Romney, WV 26757
Fax: 304-822-4898

Name: _____ CAMP Account # _____ Session Date _____

Please read each of these pages carefully and provide complete information. Incomplete forms and/or failure to provide the required signatures will prevent trainee from participating in all activities. **We must have an original physician's signature on the Scuba Health Form & Medical Release before we can consider your participation in the Underwater Astronaut Training activity. We cannot accept physician assistant, nurse practitioner or stamped signatures.** Return completed forms no later than four weeks prior to camp session start date. Maintain a copy for your records.

Scuba Waiver & Release Agreement

You must be 14 years old at the time of camp to SCUBA dive. No exceptions! Parent/guardian, trainee and witness must sign this form. Incomplete forms and/or failure to provide the required signatures will prohibit trainee from diving.

Trainee: _____ Date of Birth: _____ / _____ / _____
LAST NAME FIRST MI MONTH DAY YEAR

Account Number: _____ Session Date: _____

For and in consideration of permitting me (print name),❶, _____ to participate in skin and scuba diving activities and/or instruction provided by the U.S. Space & Rocket Center™, SPACE CAMP®, ACADEMY® involved in the activity and/or training. ❷ NAUI, other nationally recognized diving agencies, the U.S. Space & Rocket Center, SPACE CAMP, ACADEMY, their employees and agents such activities and/or training in the city of Huntsville, county of Madison, in the state of Alabama, with scheduled activities to begin on (enter date)❸ _____ , 20 ___, I state and agree as follows:

I hereby voluntarily release, discharge, waive and relinquish any and all claims or cause of action for personal injury, property damage or wrongful death occurring to me and arising as a result of engaging in skin and scuba diving activities and/or instruction and any activities incidental thereto, wherever and however such injuries may occur and for whatever period of time said activities or instructions may continue, and I do for myself, my heirs, executors, and administrators and assigns hereby release, waive, discharge and relinquish any actions to causes of action which may hereafter arise for me or my estate, and I agree that under no circumstances will I or my heirs, executors, administrators and assigns prosecute, present any claim for personal injury, property damage or wrongful death against any of those identified in ❷ above, as a result of the negligence or otherwise, of those parties in ❷ above.

I have been fully advised of the hazards and dangers incidental to engaging in the activity and/or instruction of skin and scuba diving and I hereby assume all such risks and dangers attendant to those activities, including negligence, if any, of those parties named in ❷ above.

BY SIGNING THIS AGREEMENT, I RELEASE NAUI, AND THE OTHER PARTIES IN ❷ ABOVE, FROM ANY CLAIM OR CAUSE OF ACTION I, OR MY ESTATE, MAY HAVE FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH ARISING FROM SKIN AND SCUBA DIVING ACTIVITIES AND/OR INSTRUCTION, WHETHER CAUSED BY THE NEGLIGENCE OF SAID PARTIES OR OTHERWISE. I AGREE TO HOLD NAUI AND THE AFOREMENTIONED PARTIES HARMLESS FOR ANY INJURY OR DEATH WHICH MAY OCCUR TO ME DURING SKIN AND SCUBA DIVING ACTIVITIES AND/OR INSTRUCTION.

I hereby declare I am of legal age and am competent to sign this waiver and release agreement or that my parent or guardian has signed this document on my behalf if I am a minor. **Missing or improperly placed signatures or any alterations to this form will prohibit me from participating in diving activities.**

I HAVE READ THIS AGREEMENT, UNDERSTAND IT, AND I AGREE TO BE BOUND BY IT.

_____
TRAINEE SIGNATURE **PARENT/GUARDIAN SIGNATURE (Required if trainee is under 18 years of age)**

_____
WITNESS SIGNATURE **PRINT WITNESS NAME**

If applicable, phone number where a parent/guardian may be reached during day: ( ) _____

What is the UAT?

Please initial each section after reading. Parents initials required if trainee is under 18 years of age.

_____ ***Parent Initials***

The UAT/Underwater Astronaut Trainer, at the U.S. Space & Rocket Center in Huntsville, Alabama, is a neutral buoyancy simulator like those used by the astronauts and design engineers at NASA's Johnson Space Flight Center and Marshall Space Flight Center. Neutral buoyancy simulators allow astronauts to practice on Earth the missions that they will do in space.

_____ ***Trainee Initials***

Advanced Academy trainees participate in neutral buoyancy/microgravity simulations similar to those used by the astronauts in practicing for space missions. In order to dive safely, there is a one hour classroom orientation on basic SCUBA concepts and safety practices. Trainees also undergo in-water instruction on our 4-foot training platform to prepare for neutral buoyancy exercises. Approximate SCUBA time is 1.5 to 2 hours.

_____ ***Parent Initials***

There are medical conditions that disqualify a person from participating in SCUBA activities. Insulin-dependent diabetics, epileptics, persons with a history of reactive airway disease or asthma, and persons with certain other medical conditions WILL NOT dive.

This list is not all-inclusive and other conditions may warrant disqualification from diving. All SCUBA forms are reviewed by our medical staff and our instructors who make the final determination on fitness to dive. Ultimately, the medical staff and staff instructors will decide who does and does not dive.

_____ ***Trainee Initials***

Even if it is well-controlled, IDDM (Insulin-dependent diabetes) disqualifies a diver because the warning symptoms of hypoglycemia may be suppressed, resulting in loss of consciousness without warning and because an insulin reaction underwater could very well result in drowning.

Epilepsy disqualifies a diver because underwater, a diver may be exposed to possible triggering stimuli for convulsion. Convulsions underwater often involve breath holding during the tonic and clonic phases, making pulmonary barotrauma likely, as well as drowning.

Major concerns with reactive airway disease are that the asthmatic diver could develop bronchospasm while diving and is at risk of pulmonary barotrauma, even with a normal ascent. Underwater, the diver is exposed to many factors which may precipitate bronchial spasm: exercise, cold air, dry air, and anxiety with hyperventilation. Asthmatics can have non-communicating air spaces even on full inspiration, further increasing the likelihood of pulmonary barotrauma. Resolved childhood asthma can recur later in life and may be precipitated by the cold, dry air in SCUBA cylinders, the increased pressure experienced in going to depth, stress, anxiety, or the warm water of our facility.

_____ ***Parent Initials***

If a trainee is disqualified from diving because of a medical condition or for any other reason, he or she has the option of snorkeling or swimming in the tank while the other members of the team dive. Or, the counselor may provide an alternate activity if the trainee does not wish to swim. It is important to remember that the actual SCUBA portion of Academy is about 1.5 to 2 hours out of the entire week.

_____ ***Trainee Initials***

The knowledge and skills taught as a part of the NAUI Entry SCUBA Experience will allow trainees to participate safely in certain activities when under the direct supervision of a NAUI or other nationally recognized agency-certified instructor, assistant instructor, or divemaster. It is not, however, a certification course. Additional training is necessary for certification before attempting to dive without leadership supervision.

Further questions can be directed to the Water Training Facilities Office at the U.S. Space and Rocket Center at 256-721-7190 or to the Divers Alert Network Information Line at 919-684-2948

Parental or physician medical questions or comments should be directed to the Divers Alert Network at 919-684-2948, the Underwater Astronaut Trainer at 256-721-7190, or e-mail us at: danak@spacecamp.com.

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Name: _____ CAMP Account # _____ Session Date _____

SCUBA Health Form & Medical Release You must be 14 years old at the time of camp to SCUBA dive. No exceptions! Physician, parent/guardian and trainee must sign this form. Nondisclosed health information, incomplete form and/or failure to provide required signatures will prohibit trainee from diving.

■ TRAINEE INFORMATION Please Print:

Trainee: _____ Group Name (if Applicable) _____

Account # _____ Session Date: _____ Age at time of camp: _____ Date of Birth: _____ / _____ / _____ Sex: _____

Parent's Name (applicable if trainee is under 18 years old)_____

Address: _____ City: _____ State: _____ Zip:_____

Day Time Telephone: ( ) _____ Evening Telephone: ( ) _____ FAX: ( ) _____

E-mail Address: _____

Emergency Contact: _____ Relationship to Trainee: _____ Telephone: ( ) _____

Is trainee covered by health insurance: ☐ NO ☐ YES, please attach copy of insurance card or claim form.

Does trainee have any learning disabilities? Please explain_____

_____

Drug Allergies: _____ Food Allergies: _____

Diet Restrictions: _____

Are immunizations up-to-date? ☐ Yes ☐ No If no, please attach an exemption form or explanation. Date of last tetanus booster: _____

Prescription medications trainee will require while at camp: _____ _____ _____

The following generic medications are stocked in the clinic and dispensed free of charge as needed: acetaminophen, ibuprofen, decongestant, antihistamine, cough suppressant, throat lozenges, motion sickness medication, anti-nausea, anti-diarrheal, milk of magnesia, antibiotic ointment, anti-itch cream, ipecac, topical oral pain reliever.

■ MEDICAL HISTORY

Check each item that applies to the trainee's past or present medical history. If any item is checked, a physician's remark must be included. A physician's signature and office telephone number are required. **Final determination concerning fitness to dive will be made by the SPACE CAMP medical staff and UAT Scuba Diving Coordinator.**

- ☐ Glasses/contact lenses
- ☐ Dental plates
- ☐ Physical disability
- ☐ Motion sickness
- ☐ Currently pregnant
- ☐ Migraines
- ☐ Sinus trouble and/or severe allergies
- ☐ Mental, emotional and/or behaviorial problems
- ☐ Blood pressure problems
- ☐ Non or poor swimmer
- ☐ Ear problems (e.g., surgery, frequent infections)
- ☐ Any serious medical problems/injuries (List here)

_____

_____

_____

- ☐ Diabetes
- ☐ Dizziness/fainting
- ☐ Recreational drug use
- ☐ Pulmonary problems — any history of asthma, (stress, exercise or allergy induced) reactive airway disease. Bronchiospasms disqualifies a trainee from diving in the UAT. **Trainees with any history of insulin dependent diabetes, epilepsy, reactive airway disease, or asthma will not dive.**
- ☐ Epilepsy
- ☐ History of Cardiovascular disease or problems
- ☐ Regular medication(s) (List here)

_____

_____

_____

_____

_____

Date of last chest X-ray: _____

(Necessary only with recent bronchitis, pneumonia or TB)

☐ Hospitalizations and/or surgeries (List here)

_____

_____

_____

_____

APPLICABLE FOR ADVANCED SPACE ACADEMY TRAINEES: ALL prescriptions, over-the-counter medications, vitamins and herbal products are collected and administered by nursing staff and MUST be in original containers with labels and dispensing instructions in English. Individuals requiring injections should provide medications, syringes and written instructions signed by physician.

■ PHYSICIAN'S MEDICAL STATEMENT

A physician's signature is mandatory and trainee cannot participate in all activities without it. Trainees maintain a vigorous pace from 7 a.m. to 9 p.m. During simulator training, individuals may experience up to three G's of gravitational force, strobe or flashing lights or fluid shifts. Persons with cardiac conditions, severe pulmonary dysfunctions, sensory handicaps or chronic illness may not be able to participate fully in the program. Advanced SPACE ACADEMY recommends that trainee has received a physician's examination within one year prior to session date.

I have examined _____on _____ , 20_____. I verify that trainee is in good health and physically and mentally able to participate in this program. Trainee does not have any injury, illness or disability that will prohibit participation in any activity, including scuba diving.

☐ **Approved for scuba diving:** I find no medical conditions I consider to be incompatible with scuba diving.

☐ **Not Approved for scuba diving:** Patient has medical conditions which would constitute unacceptable hazards to health and safety while diving.

Physician's name (Please print)_____

Physician's phone number ( ) _____

Physician's signature X _____

Original signature required! We cannot accept Physician Assistant, CNP or stamped signature!

Physician remarks:

_____

_____

_____

■ STATEMENT OF FITNESS TO DIVE

I certify that the information provided herein is correct to the best of my knowledge. I understand that skin and scuba diving are strenuous activities involving significant pressure changes and that a normal, healthy heart, lungs, ears and sinuses are essential prerequisites for my safety and well-being. I hereby confirm that my circulatory systems and body air spaces are healthy and normal, and that I have no severe emotional, neurological problems or communicable diseases. I understand that approval from a licensed physician is required to ascertain my physical fitness for the rigors of diving.

Trainee name (Please print) _____ **Trainee signature** X _____

If trainee is a minor, a parent/guardian signature is required. **Parent/Guardian signature** X _____

(**YOUTH PROGRAM TRAINEES only** complete this section)

■ AUTHORIZATION FOR MEDICAL TREATMENT (Must be signed!)

_____ has my permission to take any over-the-counter medications (listed above) as needed with the exception of _____ while attending this program. I verify that you have my permission to take _____to the nearest medical facility for emergency treatment and I assume responsibility for payment.

Parent/Guardian signature X _____ Date _____

(**ADULT PROGRAM TRAINEES only** complete this section)

■ AUTHORIZATION FOR MEDICAL TREATMENT (Must be signed!)

I verify that you have my permission to take me to the nearest medical facility for emergency treatment and I assume responsibility for payment.

Adult Trainee signature X _____ Date _____