

# Discovery Bay Marine Laboratory

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City \_\_\_\_\_ Country \_\_\_\_\_

Telephone \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Sex \_\_\_\_\_

Next of Kin (name, address, telephone) \_\_\_\_\_

Ailments Suffered: please tick in appropriate column below; enter age if condition is past

| Yes                      | Age                      | No                       |                               | Yes                      | Age                      | No                       |                           |
|--------------------------|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>HEAD</b>                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>NECK &amp; BACK</b>    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Recurrent headaches           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Back injury/trouble       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Severe head injury            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Migraine                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>BONE &amp; JOINT</b>   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Concussion                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swollen/painful joints    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>EYES</b>                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bone disability/deformity |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Contact lenses                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Paralysis                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Broken bones/amputations  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>EAR, NOSE &amp; THROAT</b> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Deafness                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>ABDOMEN</b>            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ruptured Eardrum              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gastrointestinal illness  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Perforated Eardrum            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhoea                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Ear infections        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic colds                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hernia                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sinusitis                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Appendicitis              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hay fever                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sugar/albumin in urine    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nose operation                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>NERVOUS SYSTEM</b>     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>HEART &amp; LUNGS</b>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervous depression        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Claustrophobia            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Wheezing                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Amnesia                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions/epilepsy      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>CHRONIC DISEASES</b>   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart palpitation             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tumour/growth/cyst        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney trouble            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart trouble                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bronchitis                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>IMMUNISATIONS</b>      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tetanus                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Collapsed lung                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pleurisy                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>ADDICTIONS</b>         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Scarlet fever                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other drugs               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>OTHER</b>                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dental plate                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                           |

Have you had any infectious diseases?..... Name them:.....  
.....

Do you regularly or frequently take any medication or other treatment with or without prescription?.....  
.....

Name any drugs to which you have had an unfavourable/allergic reaction:  
.....

No. of cigarettes/cigars/pipes smoked per day? .....

Have you had any previous diving accidents/problems or any form of decompression illness? .....

Do you have any bleeding disorders? .....

If female, are you pregnant or do you suffer from premenstrual tension?  
.....

Describe (with dates) any serious illness/injury, major surgical operation other than those already noted above: .....

Have you consulted a Doctor in the past year? .....

Do you get anxiety spells or hyperventilation? .....

Have you ever been refused a diving medical certificate, driver's licence, life insurance or been offered special terms? .....

Have you ever had any medical problems not listed? .....

Name them: .....

I hereby declare that to the best of my knowledge, I am in good general health and that the above information is correct and that I have not omitted any information which might be relevant to my fitness for diving.  
I authorise any Doctor who has attended me to disclose any details of my past or present medical history if requested to do so to the Director/Diving Officer of the Discovery Bay Marine Laboratory.

Signed ..... Date .....

**SECTION B:** (to be completed by the examining Doctor after referring to the accompanying Medical Standards.)

**NOTES TO THE EXAMINING PHYSICIAN:** This person is an applicant for diving with self contained underwater breathing apparatus (SCUBA). This is an activity that puts unusual strain on the individual in several ways.

**\*\* N.B.** SCUBA Diving requires heavy exertion, therefore the applicant "must" be free of cardiovascular and respiratory diseases. An absolute requirement is the ability of the middle ear and sinuses to equalize pressure. "Any" condition that risks the loss of consciousness should disqualify the applicant.

References of value to the Physician:

Davis, J.C. (editor)      MEDICAL EXAMINATION OF SPORT SCUBA DIVERS  
    1986 (highly recommended)  
 Dueker,                      MEDICAL ASPECTS OF SPORT DIVING      1970  
 Miles,                        UNDERWATER MEDICINE      1969

For further information, please see the accompanying MEDICAL STANDARDS. Queries should be referred to a "Hyperbaric" Physician.

| Organ                                 | Normal                   | Abnormal                 | Notes |
|---------------------------------------|--------------------------|--------------------------|-------|
| <b>Ears:</b>                          |                          |                          |       |
| R. Drum                               | <input type="checkbox"/> | <input type="checkbox"/> |       |
| Canal                                 | <input type="checkbox"/> | <input type="checkbox"/> |       |
| L. Drum                               | <input type="checkbox"/> | <input type="checkbox"/> |       |
| Canal                                 | <input type="checkbox"/> | <input type="checkbox"/> |       |
| <b>Sinuses, Nose, Throat</b>          | <input type="checkbox"/> | <input type="checkbox"/> |       |
| <b>Chest</b>                          | <input type="checkbox"/> | <input type="checkbox"/> |       |
| <b>CVS</b>                            | <input type="checkbox"/> | <input type="checkbox"/> |       |
| <b>BP</b>                             | <input type="checkbox"/> | <input type="checkbox"/> |       |
| <b>Abdomen</b>                        | <input type="checkbox"/> | <input type="checkbox"/> |       |
| <b>CNS</b>                            | <input type="checkbox"/> | <input type="checkbox"/> |       |
| <b>Joints &amp; Limbs</b>             | <input type="checkbox"/> | <input type="checkbox"/> |       |
| <b>Personality or Mental Disorder</b> | <input type="checkbox"/> | <input type="checkbox"/> |       |
| <b>Urine:</b>                         |                          |                          |       |
| Free from albumen                     | <input type="checkbox"/> | <input type="checkbox"/> |       |
| Free from sugar                       | <input type="checkbox"/> | <input type="checkbox"/> |       |

Impression: ..... APPROVAL (I find no defects which I would consider incompatible with SCUBA Diving.)

..... DISAPPROVAL (This applicant has defects which in my opinion would constitute unacceptable hazards to health and safety in SCUBA Diving.)

Doctors Name .....

Signature ..... Date .....

Address ..... Tel (.....) .....

## "MEDICAL STANDARDS"

(These notes are included for the guidance of Doctors who may be unfamiliar with the requirements for diving. If in doubt, please refer to a Hyperbaric Physician/Referee.)

The following code applies: (df) - disqualifying factor(s).  
(af) - allowable factor(s).  
(op) - other points.

**General:** (df) Gross obesity, 20% in excess of desirable body weight.

**E.N.T.:** (df) Perforated eardrum or chronic vestibular disease in new entrants.

(af) Perforated eardrum known to have been present during several years of diving.

Healed perforations, including 'paper thin' scars.  
Successful tympanoplasty.

Unilateral nasal block.

Sinusitis if not adversely affected by diving.

(op) Valsalva/Frenzel test of drum mobility optional, but out-weighed by practical diving test.

Deafness at discretion of Referee, the candidate may be restricted to diving with a fit companion.

Sinusitis may benefit from diving!

**Oral Cavity:** (df) Dentures must be retained in place on fully opening the mouth and not be dislodged by placing jaws together in any position, or by movement of one denture against another.

They should extend to the muco-buccal fold.

If dentures do not satisfy these requirements, they should not be worn while diving.

Cleft palate not acceptable without Referee's opinion.

(op) Applicants to be advised about bad teeth/fillings but these do not normally apply.

**Resp'y System:** (df) Suspicion of active tuberculosis.

Lung cysts or bullae, even after surgical treatment.

TB scars other than healed primary focus in new entrants. History of spontaneous pneumothorax.

Exercise/emotionally induced asthma, even if controlled by medication/inhaler to disqualify.

(af) Traumatic pneumothorax not necessarily a disqualifying factor; any surgical removal of lung tissue or any serious lung complaint to be referred to Referee.

(op) Initial chest Xray required. Repeat Xrays only if

indicated by history/examination. Miniatures normally acceptable; full size film may be required in doubtful cases. Examining Doctor must see Chest Xray or report. If not available, Diving Officer must see valid report.

- CVS** (df) Clinical, or where appropriate, ECG evidence of ischaemic heart disease, Aortic valve disease.  
Evidence of heart disease should be referred.  
Symptomatic or pathological arrhythmias, systolic pressure over 140 mmHg, diastolic pressure over 100 mmHg in established divers and 90 mmHg in new entrants, or other evidence of hypertensive disease.  
Major anti-hypertensive therapy.  
End organ damage from hypertension.  
Intra-cardiac shunts and fixed rate pacemakers.
- (af) Minor asymptomatic heart disease other than ischaemic (subject to more frequent medical checks).  
Mild anaemia, but advise treatment.  
Diuretics and low doses of mild vasodilators and betablockers when used alone for the control of hypertension may be permissible at the discretion of a Referee.
- (op) Post exercise ECG recommended every 5 yrs after age 40, or earlier if any suspicion of heart disease/bad family history.  
ECG not otherwise routinely required but advise obtaining baseline graph for future comparison/evaluation.

- Haematology:** (df) Haemophilia, sickle cell disease and polycythaemia.  
(af) Mild anaemia but advise treatment.  
Tumours and leukaemia may be allowable but should be referred.  
Sickle cell trait.

- Abdomen/UGS:** (df) Significant proteinuria until the cause has been established.  
(af) Peptic ulcer unless unduly active or troublesome.  
Abdominal hernias but advise repair.  
(op) Pregnant women advised not to exceed 20 meters or to go within 15 min. of no-stop time for depth.

- Nervous System / Vision:** (df) History of confirmed epilepsy including post traumatic fits, no matter how long since last episode, whether or not controlled by medication.  
Any serious head injury in last 3 months.  
Overt psychiatric or personality disorders.  
Any disease of CNS/MS, poliomyelitis, etc refer to Referee.

Petit Mal Episodes.

Radial keratotomy permanently disqualifying.

(af) Febrile convulsions but no other type of fit allowable.

(op) A single isolated fit or head injury to be referred to Referee.

Use of Timoptic eye drops can affect heart rate and response to stress.

**Drugs:** (df) Use of the following;

Sympathomimetics, steroids, Betablockers, muscle relaxants, anti-hypertensives, all diabetic drugs, digoxin.

Alcohol abuse or other drug addiction.

(af) Antihistamines and analgesics should only be used with caution.

Oral contraceptives and diuretics allowable.

Smoking allowable but reduces fitness and predisposes to air embolism, pneumothorax and coronary thrombosis.

(op) If any psychotropic drug (including tranquilisers, sedatives and hypnotics) have been used, the candidate should not dive for at least three months after complete cessation of therapy without the consent of a Referee.

Use of *Cannabis sativa* predisposes to 'flashback episodes' for 54 hours afterwards.

Possible increased risk of decompression sickness from use of contraceptive pill.

**DCS:** (df) Current/residual symptoms of any previous diving disorder eg. decompression sickness.

(op) Predisposes to repeat 'hit' of greater severity, also responds more slowly to treatment.

**Limbs:** (df) Disease, amputation or deformity excessively limiting ability to swim. Issuance of restricted certificate possible.

(af) Arthritis, amputation or arthrodesis not severely limiting ability to swim or rescue others.

(op) If ability to rescue others is impaired, must not dive with less than two healthy and experienced companions.

**Endocrine:** (af) Diabetes; only if well controlled by small doses of medication, candidates dive buddy should be informed, candidate should wear Medialert Bracelet/Chain, candidate should not be allowed to lead dives.

(op) Referral to Referee is suggested for all endocrine disorders.