

UNCW Participant Information Form

Principal Investigator: _____ Mission #: _____
Duration of Participation: ____/____/____ to ____/____/____

Name of Participant: _____ Birth Date: _____
Home Address: _____
City and State: _____
Zip Code: _____ Phone #: _____
Institution: _____ Phone #: _____

In an Emergency, Notify: _____ Relationship: _____
Home Phone #: _____ Work Phone #: _____
Address: _____
City and State: _____ Zip Code: _____

You will not be allowed to participate unless you are covered by your employer's Worker's Compensation Policy or your own health insurance policy, which covers boating and/or diving accidents, or other Diving Accident Insurance, during the period that you will be participating in UNCW research activities.

Do you have such coverage? (At the sole discretion of the UNCW/CMS Diving and Boating Safety Officer, proof of insurance may be required before participating in the research activities.)

Yes

No

Insurance Company's Name: _____
Medical/Hospitalization Insurance Policy #: _____
Phone Number of Office Holding Policy: _____

I understand that marine related activities, including boating and diving, are strenuous activities that require stamina and good health as essential prerequisites for my safety and well being. I understand and agree that there are risks and hazards inherent to boating and diving activities that include the possible consequences of serious injury, including paralysis, or death. I affirm that I can swim and if I cannot, I will agree to wear a life preserver while participating in this activity. I hereby confirm that I have no emotional or health problems incompatible with boating and diving activities. I understand that I need the approval of a physician if I am uncertain as to my physical fitness for the rigors of boating activities. I understand that I may be required to seek approval from a physician if there is a health or safety question relative to my condition before being allowed to participate in boating or diving activities.

I understand that the availability of medical emergency assistance will be limited or non-existent while participating in at-sea research activities, and that successful treatment of injuries requires

early and immediate treatment. Consequently, UNCW often provides staff that are certified to render immediate basic, and when available, advanced life-support care for all medical emergencies occurring during boating and diving activities. I have read the above statement and affirm that it is correct, and being fully informed of the possibility of injury and even death during boating and diving activities, I do hereby grant qualified UNCW staff permission to treat any injury that may occur including first aid, cardio-pulmonary resuscitation, emergency oxygen first aid, recompression therapy, and transfer to a medical facility for treatment by a physician.

Check the appropriate blank for any that applies to you, and explain under remarks.

1. Motion sickness	12. Diabetes	23. Hay fever
2. Hospitalized	13. Tuberculosis	24. Asthma
3. Serious Injury	14. Bronchitis	25. Trouble equalizing pressure in sinuses/ears
4. Back problems	15. Claustrophobia	26. Frequent colds or sore throat
5. Physical handicap	16. High blood pressure	27. Severe or frequent headache
6. Regular medication	17. Respiratory problems	28. Ear or hearing problems
7. Allergies, including drugs	18. Persistent cough	29. Alcohol or drug problems
8. Dizziness or fainting	19. Pregnant	30. Mental or emotional problems
9. Epilepsy	20. Chest pains	31. Current communicable disease
10. Heart trouble	21. Contact lenses	32. Rejected from an activity for medical reasons
11. Sinus trouble	22. Dental plates	33. Any medical problem not listed

Clearly print or type remarks:

I certify that the above information is correct to the best of my knowledge. I further understand that treatment for any medical problems I may suffer is my responsibility and will be paid for by me.

Participant's Signature

Printed Name

Date

If participant is a minor (under 18 years of age), a parent or guardian must also sign this form.

Parent or Guardian's Signature

Printed Name

Date