Medical Fitness Form for Tandem Skydiving at Skydive Spa

Address: Rue de la Sauvenière 122 4900 SPA
Phone: 087 26 99 06
Date:

Customer Information

1. **Name:** _____
2. **First name:** _____
3. **Date of Birth:** _____
4. **Phone Number:** _____

Medical Assessment

I, the undersigned, Dr. _____, physician, hereby certify that I have examined the above patient and have considered his medical history.

1. **Medical History:**
    1. Heart problems: Yes / No
    2. Respiratory problems: Yes / No
    3. Neurological Problems: Yes / No
    4. Epilepsy problems: Yes / No
    5. Shoulder dislocation problems: Yes/No
    6. Other (specify): _____
2. **Current Medications:**
    1. _____
3. **Physical examination:**
    1. Weight: _____ kg
    2. Size: _____ cm
    3. Blood Pressure: _____ mmHg
    4. Heart Rate: _____ bpm
4. **Ability to participate in a parachute jump:**
    1. The patient is fit to perform a tandem parachute jump: Yes / No
    2. Additional Notes: _____

Doctor's signature

1. **Doctor's Name:** _____
2. **Specialty:** _____
3. **Date:** _____
4. **Signature :** _____

Remarks

1. This form must be completed by a licensed physician.
2. The skydiving center reserves the right to refuse any person who does not have adequate medical fitness.

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