Pete Mesley's Lust4Rust diving excursions & SHOCK and AWE BIG Animal Diving

Lust 4 Rust TRIP BOOKING FORM DETAILS

Date of trip being booked: ____________________ Destination of trip: ____________________

NAME OF DIVER: ____________________ DOB: ____________________

Full Contact Address: ____________________

____

Email: ____________________

Contact numbers: (H)____________________ *(Mob)* ____________________

Signature: ____________________

(by signing this form you agree to all the booking conditions)

Next of Kin of diver*:* ____________________

Full Contact Address: ____________________

Email: ____________________

Contact Numbers)please put full international codes: (H)____________________ *(Mob)* ____________________

DAN INSURANCE # ____________________ (exp) ____________________

TYPE OF POLICY: ____________________

HIGHEST CERTIFICATION:____________________ (hours experience at this level) ____________________

CERT CARD #:____________________ Training Agency: ____________________

NOTE: Please indicate your highest level of certification and include a photocopy or scan of the front and back of your certification card. Rebreather CCR cards with highest level of qualification would be appreciated..

TOTAL DIVING exp in HOURS:____________________

Please Select:____________________ Type of CCR: ____________________

TANK SIZE/Setup:____________________ Sorb needed in kg: ____________________

Tmx you require:____________________ Deco Mix you require:____________________

Additional Gear needs: ____________________

____

Please note that hireage costs will be incurred unless previously agreed. If you are completely self sufficient then just put NO gear needed.!

LIABILITY RELEASE AND EXPRESS ASSUMPTIONS OF RISK FOR DIVING

THIS IS A RELEASE OF YOUR RIGHTS TO SUE PETE MESLEY, AND/OR ANY OF THEIR EMPLOYEES, AGENTS AND ASSIGNS, AND ANY ENTITY FOR PERSONAL INJURIES OR WRONGFUL DEATH THAT MAY OCCUR DURING YOUR FORTHCOMING DIVE ACTIVITIES AS A RESULT OF THE INHERENT RISKS ASSOCIATED WITH SCUBA (OR CCR) DIVING/SNORKELING AND THE UNIQUE ENVIRONMENT.
Please place your initials next to each of the following sections:

1. I acknowledge that I am a certified scuba Diver or CCR diver. My Highest certification level is

____

agency name card # date certified

NOTE: Please indicate your highest level of certification and include a photocopy of the front and back of your certification card. Rebreather divers - CCR cards with highest level of qualification would be appreciated..

2. I have _____________ hours of diving experience on the above certification level. Total mount of hours of diving is ____.

3. I carry adequate Medical/Diving Insurance (where applicable) to handle any medical problems I may develop in connection with my upcoming dives.

4. I understand that diving with compressed air or mixed gases (or on a Rebreather) involves certain inherent risks, including decompression sickness, embolism, Oxygen Toxicity, or other hyperbaric injuries. I further understand that even though I follow all of the appropriate dive practices, there is still some risk of sustaining these injuries, and I expressly assume the risk and responsibility of said injuries.

5. I certify that I am in good physical and mental health and any health concerns have been addressed by visiting a diving medical professional rendering me fit to dive. If you answer YES to any of the questions in the attached RSTC Medical form you will be required to undergoe a divers medical. Details of that form are to be attached.

6. If I suspect that I have DCS I will immediately inform the dive supervisor or tour leader.

7. I understand that I will always dive safe, not put myself or others at risk. If I do put myself or other people at risk I will not be able to continue diving with this group.

8. I understand that scuba (and CCR) diving are physically strenuous activities and that I will be exerting myself during my diving activities. If I am injured as a result of a heart attack, panic attack, hyperventilation or other injury/illness related to diving, I expressly assume the risk of all said injuries.

9. I understand that safe practices for scuba (or CCR) diving include but are not limited to the following:

a) I will **not** scuba (or CCR) dive while under the influence of alcohol, drugs and/or any other controlled substance.

b) I will **not** dive alone or with a person whom I have not thoroughly discussed the dive plan. Each of us will review one another's diving equipment and emergency procedures before each dive.

c) I will dive with properly maintained and serviced regulators, Ensuring that **ALL OXYGEN CLEANING** is done within 12 months of the trip dates on ALL regulators with anything higher than EAN40 (or as stated by the manufacturer, and Serviced by a Proper service agent. buoyancy control device that has a power inflation system, a depth gauge, a submersible pressure gauge and a timing device.

d) I will adjust weights to maintain neutral buoyancy with no air in my buoyancy control device at the surface of the water and position weights to keep the quick-release buckle centered and accessible at all times.

e) I will **not** dive in conditions I which I do not feel comfortable or that I believe exceed my physical abilities, overhead environments and other dangerous environments.

f) I will surface with at least 30-50 bar in my air tank (DIL) and no less than 30 bar of O2 and will not stay underwater until my gas supply has exhausted.

g) I am proficient with the use of a dive table and/or a dive computer and (or) can plan extended decompression dives if appropriately trained.

h) I understand that the boat captain and dive supervisor (s) will make the final selection of dive location, based upon the weather conditions, and I will abide by their selection.

i) (For CCR divers only) I will **not** exceed the single maximum CNS dose or daily dose both with

CNS or OTU and if levels exceed 100% you will be required to stand down for 12 hours

J) (For CCR divers only) I will **not** dive if my rebreather is faulty or shows (but not limited to) cell failure, Low battery, controller problems before the dive and if I have any failures I will end the dive immediately.

10. I state that I am at least twenty-one (21) years of age and legally competent to sign this Liability Release and Express Assumption of Risk.

11. I understand that this Liability Release and Express Assumption of Risk constitutes a contract between myself and the released parties listed above and that I have signed this document of my own free will

I HAVE FULLY INFORMED MYSELF OF THE CONTENTS OF THIS LIABILITY RELEASE AND EXPRESS ASSUMPTION OF RISK BY READING IT BEFORE I SIGNED IT ON BEHALF OF MYSELF, AND HEIRS AND MY ESTATE.

Printed name of diver: ______________________________ DOB: ____________________

Signature of diver: ______________________________ Date ____________________

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 ☐ *Go to Box A*	No ☐
2. I am over 45 years of age.	Yes ☐ *Go to Box B*	No ☐
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 ☐*	No ☐
4. I have had problems with my eyes, ears, or nasal passages/sinuses.	Yes ☐ *Go to Box C*	No ☐
5. I have had surgery within the last 12 months, OR I have ongoing problems related to past surgery.	Yes ☐*	No ☐
6. I have lost consciousness, had migraine headaches, seizures, stroke, significant head injury, or suffer from persistent neurologic injury or disease.	Yes ☐ *Go to Box D*	No ☐
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 ☐ *Go to Box E*	No ☐
8. I have had back problems, hernia, ulcers, or diabetes.	Yes ☐ *Go to Box F*	No ☐
9. I have had stomach or intestine problems, including recent diarrhea.	Yes ☐ *Go to Box G*	No ☐
10. I am taking prescription medications (with the exception of birth control or anti-malarial drugs other than mefloquine/Lariam).	Yes ☐*	No ☐

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 ☐*	No ☐
Asthma, wheezing, severe allergies, hay fever or congested airways within the last 12 months that limits my physical activity/exercise.	Yes ☐*	No ☐
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 ☐*	No ☐
Recurrent bronchitis and currently coughing within the past 12 months, OR have been diagnosed with emphysema.	Yes ☐*	No ☐
A diagnosis of COVID-19.	Yes ☐*	No ☐

Box B – I am over 45 years of age AND:		
I currently smoke or inhale nicotine by other means.	Yes ☐*	No ☐
I have a high cholesterol level.	Yes ☐*	No ☐
I have high blood pressure.	Yes ☐*	No ☐
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 ☐*	No ☐

Box C – I have/have had:		
Sinus surgery within the last 6 months.	Yes ☐*	No ☐
Ear disease or ear surgery, hearing loss, or problems with balance.	Yes ☐*	No ☐
Recurrent sinusitis within the past 12 months.	Yes ☐*	No ☐
Eye surgery within the past 3 months.	Yes ☐*	No ☐

Box D – I have/have had:		
Head injury with loss of consciousness within the past 5 years.	Yes ☐*	No ☐
Persistent neurologic injury or disease.	Yes ☐*	No ☐
Recurring migraine headaches within the past 12 months, or take medications to prevent them.	Yes ☐*	No ☐
Blackouts or fainting (full/partial loss of consciousness) within the last 5 years.	Yes ☐*	No ☐
Epilepsy, seizures, or convulsions, OR take medications to prevent them.	Yes ☐*	No ☐

Box E – I have/have had:		
Behavioral health, mental or psychological problems requiring medical/psychiatric treatment.	Yes ☐*	No ☐
Major depression, suicidal ideation, panic attacks, uncontrolled bipolar disorder requiring medication/psychiatric treatment.	Yes ☐*	No ☐
Been diagnosed with a mental health condition or a learning/developmental disorder that requires ongoing care.	Yes ☐*	No ☐
An addiction to drugs or alcohol requiring treatment within the last 5 years.	Yes ☐*	No ☐

Box F – I have/have had:		
Recurrent back problems in the last 6 months that limit my everyday activity.	Yes ☐*	No ☐
Back or spinal surgery within the last 12 months.	Yes ☐*	No ☐
Diabetes, drug- or diet-controlled, OR gestational diabetes within the last 12 months.	Yes ☐*	No ☐
An uncorrected hernia that limits my physical abilities.	Yes ☐*	No ☐
Active or untreated ulcers, problem wounds, or ulcer surgery within the last 6 months.	Yes ☐*	No ☐

Box G – I have had:		
Ostomy surgery and do not have medical clearance to swim or engage in physical activity.	Yes ☐*	No ☐
Dehydration requiring medical intervention within the last 7 days.	Yes ☐*	No ☐
Active or untreated stomach or intestinal ulcers or ulcer surgery within the last 6 months.	Yes ☐*	No ☐
Frequent heartburn, regurgitation, or gastroesophageal reflux disease (GERD).	Yes ☐*	No ☐
Active or uncontrolled ulcerative colitis or Crohn's disease.	Yes ☐*	No ☐
Bariatric surgery within the last 12 months.	Yes ☐*	No ☐

*Physician's medical evaluation required (see page 1).

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 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.

______________________________ ____________________
Physican'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

Local NZ Bank transfer details for Pete Mesley (Dive TEC & Lut4Rust Dive Excursions ltd.)

Our contact details

THIS IS A NZ DOLLAR ACCOUNT

Account name: Pete Mesley t/a Dive T.E.C. & Lust4Rust Dive Excursions ltd.
Bank: BNZ (Bank of New Zealand)
Branch: Manukau City Branch,
Address: 639 Great South Rd, Manukau, Auckland, NZ
Account number: 020 191 040 7777 000
Swift code: BKNZNZ22

Pete Mesley t/a Dive T.E.C. 99 St Annes Crescent Wattle Downs, Auckland New Zealand 2013		Ph +64 (9) 2686473 Mob +64 (27) 2782250 Email pete@lust4rust.co Web www.lust4rust.co