

**Aquatic Adventures**

PLEASE ANSWER ALL QUESTIONS

**Aquatic Adventures "Whales of the Silver Bank" Expedition**

Date of Departure \_\_\_\_\_

Full Name (exactly as it appears on your passport) \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_ Date of Birth (mo/dd/yr) \_\_\_\_\_

Passport # \_\_\_\_\_ Place of Issue \_\_\_\_\_ Date of Expiration \_\_\_\_\_

Occupation \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Please specify any special dietary requirements \_\_\_\_\_

Please specify T-Shirt Size: Men's XL \_\_\_\_\_ L \_\_\_\_\_ Med \_\_\_\_\_ Sm \_\_\_\_\_ XS \_\_\_\_\_ Women's XL \_\_\_\_\_ L \_\_\_\_\_ Med \_\_\_\_\_ Sm \_\_\_\_\_ XS \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

(Please do not write person you are traveling with)

Address \_\_\_\_\_

Phone \_\_\_\_\_ Cell \_\_\_\_\_ email \_\_\_\_\_

ARRIVAL TIME/DATE/AIRLINE/FLIGHT #: \_\_\_\_\_

DEPARTURE TIME/DATE/AIRLINE/FLIGHT #: \_\_\_\_\_

Please specify any special requests required \_\_\_\_\_

**PLEASE COMPLETE IF YOU WILL BE SCUBA DIVING ON YOUR ADVENTURE**

Certifying Agency \_\_\_\_\_ Cert. Number \_\_\_\_\_ Cert. Level \_\_\_\_\_

Do you have a dive accident insurance policy? YES NO If yes, from what company? \_\_\_\_\_ Policy Number \_\_\_\_\_

Approximately how many dives have you logged previously (as of the date of signing this form)? \_\_\_\_\_

Approximately how recent was your last open water dive? (Give Date and Place) \_\_\_\_\_

Please specify wetsuit size if renting: Men's XL \_\_\_\_\_ L \_\_\_\_\_ Med \_\_\_\_\_ Sm \_\_\_\_\_ XS \_\_\_\_\_ Women's XL \_\_\_\_\_ L \_\_\_\_\_ Med \_\_\_\_\_ Sm \_\_\_\_\_ XS \_\_\_\_\_

**TRIP CANCELLATION AND INTERRUPTION INSURANCE**

We highly recommend that you purchase comprehensive accident, medical, baggage and trip cancellation/interruption insurance when space is reserved. If a pre-existing condition exists most trip cancellation insurance companies will honor these situations if insurance is purchased within 10 days of making your deposit. Trip insurance will protect you from financial disappointment in the event unforeseen circumstances prevent any **adventure** travel itinerary or vessel from making its scheduled trip. **Aquatic Adventures** will NOT be liable in the event you miss your trip and/or for any of the following expenses including but not limited to, transportation, hotel nights, meals, etc., that are not included in your itinerary. Any and all costs due to the delay of a trip, including but not limited to bad weather, airline delays, adverse itinerary conditions, illness, etc. Any costs required for excess baggage, lost or forgotten personal items or shipping fees. There will be no refund or credit issued in the event it is necessary to cancel or interrupt a trip and/or charter itinerary due to weather or any matter beyond the control of **Aquatic Adventures** and/or any of its' affiliates. We also highly recommend diving accident insurance should you be diving on your scheduled trip. Please inquire with our reservation office for assistance.

**I hereby certify that I have read and understand the foregoing statement.**

→Signature \_\_\_\_\_ Date \_\_\_\_\_

Please be sure to sign and date

**FILM AND IMAGE RELEASE AND AUTHORIZATION****I hereby give Aquatic Adventures and/or any of its' affiliates the absolute and irrevocable right and permission with respect to the photographs and/or videos that have been taken of me or in which I may be included with others:**

- To copyright the same in Aquatic Adventures name or any other name Aquatic Adventures may choose.
- To use, re-use, publish and re-publish the same in whole or in part, individually or in conjunction with other photographs or videos, in any medium and for any purpose whatsoever, including (but not in way of limitation) illustration, promotion and advertising trade.
- To use or disclose my name in connection therewith, if *Aquatic Adventures*, so chooses.

I hereby release and discharge Aquatic Adventures, and any or all it's affiliates, from any and all claims, including any and all claims for defamation and invasion of privacy. This authorization and release shall also ensure to the benefit of the legal representatives, licensees and assigns of Aquatic Adventures and any or all its' affiliates, as well as the person(s) for whom the photographs or videos were taken. I hereby certify that I have read and understand the foregoing statement.

**I hereby certify that I have read and understand the foregoing statement.**

→Signature \_\_\_\_\_ Date \_\_\_\_\_

Please be sure to sign and date

**MEDICAL HISTORY**

The following information is intended for use in the case of an emergency in the event you should be unable to supply it. YOU ALONE ARE RESPONSIBLE TO DETERMINE IF YOU ARE MEDICALLY AND PHYSICALLY CAPABLE TO TAKE PART IN ANY ADVENTURE TRAVEL ACTIVITIES INCLUDING BUT NOT LIMITED TO HIKING, LAND EXCURSIONS, BOATING, DIVING, SNORKELING, ETC.. WE TAKE NO RESPONSIBILITY WITH RESPECT TO YOUR DETERMINATION. If you have any questions concerning your medical or physical fitness to take part in any such activities, please consult your personal physician. Please check any of the following items which apply to your past medical history or present medical condition:

→Signature \_\_\_\_\_ Date \_\_\_\_\_

Please be sure to sign and date

Please check any of the following items which apply to your past medical history or present medical condition.

	YES	NO
1. HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE.....		
a) Frequent colds, sinusitis or bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>
b) Frequent or severe attacks of hay fever or allergies?	<input type="checkbox"/>	<input type="checkbox"/>
c) Asthma affects my everyday activities and/or I use medication or an inhaler regularly?	<input type="checkbox"/>	<input type="checkbox"/>
d) Heart or respiratory problems or high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
e) Tuberculosis, chronic bronchitis or emphysema?	<input type="checkbox"/>	<input type="checkbox"/>
f) Pneumothorax (collapsed lung) or any other lung diseases or problems?	<input type="checkbox"/>	<input type="checkbox"/>
g) Epilepsy, seizures, convulsions, dizziness, fainting, blackouts or take medications to prevent them?	<input type="checkbox"/>	<input type="checkbox"/>
h) Chest disease or chest surgery?	<input type="checkbox"/>	<input type="checkbox"/>
i) Diabetes, cancer or tumor of any kind?	<input type="checkbox"/>	<input type="checkbox"/>
j) Kidney or bladder disease?	<input type="checkbox"/>	<input type="checkbox"/>
k) Gout or arthritis or any back, head, neck, leg or foot problems or injuries?	<input type="checkbox"/>	<input type="checkbox"/>
l) Gastric or duodenal ulcer, colitis or intestinal problems?	<input type="checkbox"/>	<input type="checkbox"/>
m) Behavioral health, mental or psychological problems (panic attack, depression, anxiety, fear of closed or open spaces)?	<input type="checkbox"/>	<input type="checkbox"/>
n) Recurring complicated migraine headaches or take medications to prevent them?	<input type="checkbox"/>	<input type="checkbox"/>
o) Frequent or severe suffering from motion sickness (seasick, carsick, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
p) Decompression sickness (the Bends) or another diving accident?	<input type="checkbox"/>	<input type="checkbox"/>
q) Any mental and/or physical disease, illness or disability, which would render me unfit for scuba diving, scuba instruction, snorkeling, water-skiing or other water sports.	<input type="checkbox"/>	<input type="checkbox"/>

2. Are you pregnant?

If YES, how many weeks pregnant will you be at the time of travel? \_\_\_\_\_

3. During the last 5 years, have you suffered any significant illness, been hospitalized or required regular care by a doctor?

If YES, please indicate reason: \_\_\_\_\_

4. Do you have any physical limitations, handicaps or prosthesis? Do you have difficulty walking or use a device for mobility assistance such as crutches, cane or wheelchair?

If YES, please specify: \_\_\_\_\_

5. Do you have any allergies, or reactions to any medication or drugs?

If YES, please specify: \_\_\_\_\_

6. Are you affected by any other pre-existing medical conditions not listed above?

If YES, please specify: \_\_\_\_\_

**I hereby certify that the foregoing is true and correct.**

→Signature \_\_\_\_\_ Date \_\_\_\_\_