

# PARACHUTIST'S HEALTH STATEMENT

(confidential; only for the use of the training organization)

Parachutist's name and date of birth: \_\_\_\_\_

Do you have any of the following illnesses, injuries or limitations (yes / no / I don't know)?

**1. Cardiological disorders** (e.g. arrhythmia, high blood pressure, chest pain, Angina pectoris)  
yes  no  I don't know

**2. Respiratory disorders** (e.g. asthma, pneumothorax, chronic sinusitis, tuberculosis)  
yes  no  I don't know

**3. Neurological disorders** (e.g. dizziness, cramps, epilepsy)  
yes  no  I don't know

**4. Insulin-treated diabetes**  
yes  no  I don't know

**5. Dislocated joints, broken or fractured bones during the last 12 months or functional limitations** (except those that your doctor has stated as cured)  
yes  no  I don't know

**6. Regular prescribed medication** (e.g. psychopharmaceutical drugs, so-called "red triangle" drugs etc., excluding birth control pills, antibiotics, analgesic drugs, allergy drugs or other medicine not deemed by your doctor to be an obstacle to parachuting, in which case a written statement from your doctor is needed)  
yes  no  I don't know

**7. Eye disorders**  
yes  no  I don't know

## 8. Sight

Student's sight in both eyes needs to be 1.0 or better. Minimum of A-license holder's sight in both eyes needs to be 0.8 or better. Visual field of both eyes needs to be normal. A parachutist must be able to read normal text from distance of 30 cm. If fulfilling these requirements requires using eyeglasses or contact lenses, these have to be used while parachuting.

**I have to use eyeglasses or contact lenses to fulfil the sight requirements:**

yes  no

I assure that the information I've given above concerning my health is truthful. In case my medical situation changes, I shall inform the training organization accordingly.

\_\_\_\_\_  
Place Date Signature

\_\_\_\_\_  
Place Date Guardian's signature (students under 18 years old)

\_\_\_\_\_  
Guardians name (capital letters) and phone

In case of accident inform the following person: \_\_\_\_\_  
Name and phone

## LÄÄKÄRINTODISTUKSEN TARKASTUS (tarvittaessa ja yli 60-vuotialta)

Lääkärintodistus päivätty \_\_\_\_ . \_\_\_\_ . \_\_\_\_ Lääkäriin nimi ja SV-numero \_\_\_\_\_

\_\_\_\_\_  
Kerho Päiväys KP / AKP / PL-HM tai NHM