PARACHUTIST'S HEALTH STATEMENT

(Confidential; only to be checked by the training organization)

Parachutist's name and age this day: _____ ____ **years**
(Note. persons over 60 years old need medical certificate)

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, chronical 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

TERVEYDENTILAVAKUUTUKSEN TARKASTUS

HYPPYKELPOINEN: kyllä ☐ ei ☐ pitää käydä lääkärissä ☐

_____	___.___._____	_____
Kerho	Päiväys	KP / AKP / PLHM tai NHM