

# PARACHUTIST'S HEALTH STATEMENT

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

**Parachutists name and date of birth:** \_\_\_\_\_ **kg** \_\_\_/\_\_\_/\_\_\_  
 (medical certificate needed from person over 65 years of age)

## ILNESSES, INJURIES AND LIMITATIONS THAT POSSIBLY PREVENT PARACHUTING

- 1 Cardiological disorders** (E.g. arrythmia, high blood pressure, chest pain, angina pectoris)
- 2. Respiratory disorders** (E.g. asthma, pneumothorax, chronical sinusitis, tuberculosis)
- 3. Loss of consciousness** (E.g. inexplicable or repetitive fainting, spasms or epilepsy, hypoglycaemic episodes etc.)
- 4. Insulin-treated diabetes**
- 5. Neurological disorders** (E.g. epilepsy, MS, Parkinson, dementia, cerebral circulation, hemiplegic migraine etc.)
- 6. Psychiatric illness** (E.g. past or current psychosis, depression within 5 years, insomnia, ADHD or other illness requiring psychiatric or psychiatrist treatment)
- 7. Broken or fractured bones within the last 12 months, dislocated joints (ever) or joint replacements (ever)** (Except those that have been cleared by the doctor)
- 8. Hernia or fistulas** (for example but not limited to: groin, belly button, scar, intestinal fistula, urine fistula)
- 9. Limitations in body movement or body abnormality** (E.g. caused by a serious injury, birth defects or even partial paralysis)
- 10. Regular or temporary medication effecting on central nervous system** (Any medication with a red warning triangle, for example but not limited to sleeping pills, strong painkillers, any opiate related medicine, cannabis regardless of intended use, stimulants)
- 11. Abnormal operation of senses** (E.g. visual problems (glasses are not limitation), hearing impairment, abnormal sense of feel or balance, glasses are not a visual problem)

### 12. Sight

Should be 0.8 or better. Both eyes need to have normal peripheral vision. Jumper should be able to read normal text from a 30cm distance. If a jumper needs glasses or contact lenses to achieve these requirements, jumper has to use them while skydiving.

**I meet previously mentioned requirements**

yes  no

**I need to use glasses or contact lenses in order to achieve previously mentioned requirements**

yes  no

I assure that the information I give here concerning my health is truthful. In case my health status changes, I shall inform the training organization accordingly.

<input style="width: 20px; height: 20px; margin-left: 5px;" type="checkbox"/> <p>I assure that I do not have any illnesses, injuries, limitations or medications stated above that could be an obstacle to parachuting.</p>	<input style="width: 20px; height: 20px; margin-left: 5px;" type="checkbox"/> <p>I have some of the above mentioned illnesses, injuries, limitations or medications and I state my health by a medical certificate                  (instructor fills):                  Date of certificate: ___/___/_____                  Doctor's name: _____                  Doctor's SV-number _____</p>
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**Information regarding the General Data Protection Regulation (EU 2016/679, GDPR)**

Parachutist in training is obliged to provide a health statement or a medical certificate in order to substantiate adequate health for parachuting according to Finnis Aviation Association's Operational Instructions and Qualification Requirements for Parachutists. This personal data is processed according to the consent of the data subject (GDPR 9 art 2a paragraph: processing of special categories personal data based on the consent of the data subject). Information that is mandatory to provide to the data subject when collecting personal data are presented in the record of processing activities of Skydive Finland. The record is displayed at the dropzone when filling this statement. It can also be seen at website [www.skydivefinland.fi](http://www.skydivefinland.fi) or via the staff. By signing this statement the data subject states that he/she has been provided with this information and gives his/her consent.

_____	____/____/____	_____
Place	Date	Signature
_____	____/____/____	_____
Place	Date	Guardian's signature (students under 18 years of age)
		_____
		Guardian's name and phone number

In case of accident, please inform:

\_\_\_\_\_

(name and phone number)

**TERVEYDENTILAVAKUUTUKSEN TARKASTUS (organization)**

HYPPYKELPOINEN: kyllä  ei  pitää käydä lääkärissä

_____	_____	_____
Organisaatio	Päiväys	KP/AKP/PLHM tai NHM nimikirjoitus ja nimenselvennys