



RESTRICTED – MEDICAL  
(when completed)

**CADET AND STAFF ACTIVITIES CERTIFICATE OF HEALTH/DECLARATION OF FITNESS**

Surname:	Forename(s):	D of B:
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Do you or have you ever suffered from any of the following? If yes tick the box and complete the questionnaire – CC FORM 4 for each condition, attach separate information if appropriate.

Heart conditions	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Other chest conditions	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	Blackouts	<input type="checkbox"/>	Headaches	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Ear or Sinus problems	<input type="checkbox"/>
Muscular/skeletal problems	<input type="checkbox"/>	Problems with vision	<input type="checkbox"/>	Behavioural problems	<input type="checkbox"/>
Any previous major injury	<input type="checkbox"/>	Any previous major illness	<input type="checkbox"/>	Any other condition/disability	<input type="checkbox"/>

Please also complete the boxes below as fully as possible, attach a separate sheet if needed write NONE in the box if appropriate

List any medication being taken (other than the medication detailed on the questionnaire – CC FORM 4)	
List any known allergies	
Give details of any ongoing regular care required	
Give details of any special dietary needs	
Give details of any special religious needs	
Give details of any past condition/injury for which medication is not taken but which might be affected by the activity.	
NHS Number:  Name of Doctor:  Address:  Postcode:  Tel No	Declaration  I understand that I should arrive at the activity sufficiently prepared and physically fit to take a full part in the activity. I have declared all medical matters that may affect my participation. I will inform the officer in charge of any additional medical matter that may occur after signing this form.

Signature of participant:

Date:

Signed:

(Person having parental responsibility for a cadet under 16 years of age)

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**CADET AND STAFF ACTIVITIES HEALTH QUESTIONNAIRE**

**This should be completed if any box on CC FORM 3 has been ticked or other conditions eg allergies have been declared**

Surname:	Forenames:	D of B:
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Condition being declared:

Medication being taken:	Name:
	Dosage:
	Storage requirements:

Do you carry/need any emergency medication?      Yes

If Yes give details:

How are you affected by the condition by normal routine activities:

How are you affected by the condition during strenuous exercise:

Have you sought advice from your doctor/nurse about your condition in relation to the activity Yes/No      If  
yes give details of comments/advice given below

Any additional information/comments which will help you manage your condition during the activity

I fully understand that the activities may be strenuous and conducted in environmental conditions such as dust, fumes, extreme temperatures and altitudes that may aggravate my condition. I confirm that I have consulted my doctor if there is any doubt regarding the suitability of the activity or my fitness/ability to take part in the activity. Should there be any change in my condition after signing this questionnaire I will inform the Officer in Charge of the activity or the OC Sqn/Wing HQs concerned prior to travelling to the activity.

Signature of participant:

Date:

Signed:

(Person having parental responsibility for a cadet under 16 years of age)

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