

**ACF 13A (ADULT STAFF)****PERSONAL DETAILS AND CERTIFICATE OF HEALTH**

<b>Surname</b>		<b>Forenames</b>
<b>Rank</b>	<b>Service Number</b>	<b>ATC Sqn/ CCF Unit</b>
<b>Nat Health Service No:</b>		

**NEXT OF KIN/PERSON TO CONTACT**

<b>Name</b>	<b>Relationship</b>
<b>Address</b>	<b>Telephone No</b>
<b>Post Code</b>	
<b>Contact address and telephone no during camp period(if different from above)</b>	

I have volunteered to attend camp at

RAF \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_

I certify that I am fit to participate in supervisory duties at camp and to take part in what may be strenuous pursuits. I will advise my Wing Administrative Officer if I have contact with any infectious diseases in the 3 weeks prior to camp.

The information contained in this document is classified as sensitive personal information and is subject to the provisions of the Data protection Act 1998. It is necessary for such information to be retained for legal reasons. Only such data as is relevant to your attendance at the camp will be used/retained. Signing below indicates your consent for us to use and retain such data. You have the right under the Data Protection Act 1998 to request access to any personal information we hold about you.

Date \_\_\_\_\_ Signed \_\_\_\_\_

**REGARDLESS OF YOUR MEDICAL CONDITION YOU ARE REQUIRED TO COMPLETE AND SIGN THE CERTIFICATE ON PAGE 4-D-11**

CERTIFICATE OF HEALTH

Do you suffer from the following? (circle "YES" or "NO"). Amplify any problem on a separate sheet of paper sealed in an envelope marked for the attention of the SMO.

<b>Chest and Heart Conditions:</b> Other than mild chest infections, a chest or heart condition may be significant: this includes any history of asthma, bronchitis or wheezing. <b>Note: Asthma sufferers are to complete Asthmatic Medical and Consent Forms (ACP 237 Chap 4 Annex E) available from Wg HQ.</b>	YES	NO
<b>Epilepsy:</b>	YES	NO
<b>Any Loss of Consciousness or Blackouts:</b> This includes any history of fainting episodes	YES	NO
<b>Ear or Sinus Problems:</b>	YES	NO
<b>Diabetes:</b>	YES	NO
<b>Severe Headaches:</b>	YES	NO
<b>Any Other Major Illness or Injury:</b>	YES	NO
<b>Any Condition Requiring Regular Prescribed Medication:</b>	YES	NO
<b>Any Condition Requiring Regular Care, Doctor or Hospital Specialist:</b>	YES	NO
<b>Any Other Disability or pre-existing condition:</b> (if YES give details)	YES	NO
<b>Are you taking tablets or medicines?:</b> If YES, specify:	YES	NO
<b>Do you have any known Allergies?:</b> If YES, specify:	YES	NO
<b>Do you have any Diet Restrictions or Special Food needs?:</b> If YES, specify:	YES	NO

DETAILS OF DOCTOR

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

\_\_\_\_\_

POSTCODE: \_\_\_\_\_ TEL NO: \_\_\_\_\_

Date: \_\_\_\_\_ Signed: \_\_\_\_\_

(NAME IN BLOCK CAPITALS) \_\_\_\_\_