

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 well prepared, physically and sufficiently fit to take a full part in the activity. I have declared all medical matters that may affect my participation and I will inform the officer in charge of any additional medical matter that occurs after signing this form.

Signature of participant: \_\_\_\_\_ Date: \_\_\_\_\_  
 Signed: \_\_\_\_\_ (Person having parental responsibility for a cadet under 16 years of age)