THE NAVY LEAGUE OF CANADA

STAFF MEDICAL QUESTIONNAIRE

Section 1 – Personal Information

Rank	Surname	Given Name	Middle Name(s)

Street Address	City / Town	Postal Code

Gender ☐Male ☐Female	Date of Birth Day Month Year	Home Phone #	Cell Phone #

Section 2 – Medical Information

Name of Family Doctor	Phone #

Provincial Hospitalization/Insurance #	Name of Group Medical Insurance Company

Group Number	Dependant Number	Latest Tetanus Injection Month Year

Section 3 – Emergency Contact Information

Emergency Contact Name	Relationship to Staff Member

Home Phone #	Cell Phone #	Work Phone #	Ext.

The following information is required to assist the Navy League Cadet Corps in determining the capabilities of the above-mentioned Staff. All information is kept confidential.

Please indicate either **"YES"** or **"NO"** that applies to you

	YES	NO		YES	NO
Nervous trouble or breakdown	☐	☐	Rheumatism or Arthritis	☐	☐
Head injury, concussion, or headaches	☐	☐	Stomach, bowel, or rectal problem	☐	☐
Dizzy or fainting spells	☐	☐	Hernia	☐	☐
Convulsions or fits	☐	☐	Low back pain	☐	☐
Nose, throat, eye, or ear trouble	☐	☐	Kidney or bladder trouble	☐	☐
Diabetes	☐	☐	Lung disease or chronic cough	☐	☐
Skin conditions – medication	☐	☐	Foot trouble	☐	☐
Hives, hay fever, asthma, or allergy	☐	☐	Motion or travel sickness	☐	☐
Heart trouble, shortness of breath	☐	☐	Broken bones	☐	☐
Tropical diseases	☐	☐	Learning disabilities i.e. Dyslexia	☐	☐
Color blindness	☐	☐	Hearing loss or impairment	☐	☐
Stuttering	☐	☐	Menstrual problems producing disability	☐	☐
Wears corrective lens	☐	☐	PTSD	☐	☐

If you have checked **"YES"** to any of the above conditions, please give any additional information you feel is pertinent

Describe any Illnesses, injuries, or disabilities not previously listed

Please describe any allergies, reactions / symptoms, and treatments for the reactions

List any operations in the last five (5) years

Please describe any dietary restrictions

Signature	Date