



THE NAVY LEAGUE OF CANADA

MEDICAL QUESTIONNAIRE

This document must be acknowledged in section 5 by the Parent/Guardian who holds legal parental authority over the cadet.

COMPLETING THIS FORM

This form may be completed electronically and then printed or printed and then completed by hand. If it's completed by hand, print in block letters. Until this form is properly completed and handed to the Cadet Administration Officer or designate, cadets shall not be authorized to participate in training and/or activities.

FOOD ALLERGIES

It is important for Parents to be aware that the Navy League of Canada and their Corps do not have the mandate, are not equipped not staffed to offer allergen-free foods or food preparation conditions. These limitations apply to meals and snacks prepared just as much by a caterer, volunteers or parents, and for all types of programmes, courses and activities conducted throughout the year, whether locally or away. The Navy League of Canada is concerned that for those with food allergies, sensitivities and intolerance it may not always be safe to participate in all training and activities.

At Section 5, those with diet restrictions are required to indicate that they are aware of the stipulations mentioned above and still wish to participate in programmes, courses and activities during which meals are consumed.

MEDICATIONS

Parents are to make the Commanding Officer or Medical Officer aware of any medications that their child may bring and that they may require during extended activities. The medications MUST be in original containers, preferably bubble packs, with the name, drug and dosage clearly labelled. Cadets who require an inhaler or EpiPen will need to carry them at all times in an appropriate fanny pack or other carry case. They should also make the staff aware of any health concerns that may impact their health and safety, or that of others.

Please be advised that while your son/daughter is supervised by Members of the Navy League of Cadet Corps, their care and safety is of primary concern. In the event of an incident/emergency our Members will perform all actions that are deemed necessary at the time, which may include calling for Emergency Services or other professional care in your absence.

If there is a pre-existing medical condition, the Navy League's insurance Underwriter may limit coverage as a result of accident or injury related to that medical condition.

If the Cadet or his/her Parents have any questions related to any topic on this form, they can contact the cadet corps Commanding Officer.

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Section 1 – Cadet Personal Information

Rank	Surname	Given Name	Middle Name(s)
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth Day Month Year	Corps Name	Corps Location

Section 2 – Cadet Medical Information

Name of Family Doctor			Phone #	
Provincial Hospitalization/Insurance #	Expiry Date	Medical Insurance	Group Number	
Policy Number	Dependant Number	Latest Tetanus Injection Month Year	Can the cadet swim? Yes No	

Section 3 - Parent / Guardian Information

1. Name of Parent / Guardian			Relationship to Cadet	
Home Phone #	Cell Phone #	Work Phone #	Ext.	
Street Address			City / Town	Postal Code
2. Name of Parent / Guardian			Relationship to Cadet	
Home Phone #	Cell Phone #	Work Phone #	Ext.	
Street Address			City / Town	Postal Code

Section 4 – Emergency Contact Information

Emergency Contact Name (Must be different from Parents / Guardians listed in Section 2)			Relationship to Cadet	
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 Cadet to participate in certain aspects of the Training Program which including marching on hard surface, swimming, and other strenuous activities. This information will also be valuable in alerting the Corps Staff in any potential medical or physical problems which might require some attention when the cadet is undergoing training. All information is kept confidential.

Please indicate either **“YES”** or **“NO”** that applies to your cadet for each condition below

	YES	NO		YES	NO
Nervous trouble or breakdown	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism or Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Head injury, concussion, or headaches	<input type="checkbox"/>	<input type="checkbox"/>	Stomach, bowel, or rectal problem	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy or fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions or fits	<input type="checkbox"/>	<input type="checkbox"/>	Low back pain	<input type="checkbox"/>	<input type="checkbox"/>
Nose, throat, eye, or ear trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease or chronic cough	<input type="checkbox"/>	<input type="checkbox"/>
Skin conditions – medication	<input type="checkbox"/>	<input type="checkbox"/>	Foot trouble	<input type="checkbox"/>	<input type="checkbox"/>
Hives, hay fever, asthma, or allergy	<input type="checkbox"/>	<input type="checkbox"/>	Motion or travel sickness	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble, shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones	<input type="checkbox"/>	<input type="checkbox"/>
Tropical diseases	<input type="checkbox"/>	<input type="checkbox"/>	Learning disabilities (eg. Dyslexia)	<input type="checkbox"/>	<input type="checkbox"/>
Color blindness	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss or impairment	<input type="checkbox"/>	<input type="checkbox"/>
Stuttering	<input type="checkbox"/>	<input type="checkbox"/>	Bed wetting	<input type="checkbox"/>	<input type="checkbox"/>
Wears corrective lens (Glasses/contacts)	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems producing disability	<input type="checkbox"/>	<input type="checkbox"/>

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

Is the cadet presently on medication? Yes No If yes, Please fill out Appendix A.

From day to day, a Cadet may need the following **NON-PRESCRIPTION MEDICATION** given to them by our Medical Officer. Please indicate which of the following medications we may administer

		Administer		Do Not Administer
		Child Dose	Adult Dose	
FOR PAIN	Tylenol (acetaminophen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FOR UPSET STOMACH	Gravol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Pepto Bismol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Tums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FOR SOAR THROATS	Lozenges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	SINUS CONGESTION			
	Allegra	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Benadryl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Claritin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FOR RASH OR INSECT BITES	Calamine Lotion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Afterbite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Polysporin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER MEDICATION		<input type="checkbox"/>	<input type="checkbox"/>	
(must be supplied by parent / guardian)	_____	<input type="checkbox"/>	<input type="checkbox"/>	
	_____	<input type="checkbox"/>	<input type="checkbox"/>	

Section 5 – Parental Acknowledgement and Consent

If any restrictions in section 4D or 4F above, do you consent to the above named cadet participating in training and activities which she/he will have a meal under the conditions described on page 1 under the heading 'Cadets and Food Allergies'? Yes No

I certify that the information on this form is complete, accurate and valid to the best of my knowledge. I acknowledge that I am required to notify the cadet corps Commanding Officer immediately if changes to the above named cadet's medical condition render any of the information collected on this form incomplete, inaccurate or invalid.

Signature of Parent / Guardian Date


Appendix A – Current Medication

Name of Medication		Amount Taken
How Often (check one) <input type="checkbox"/> Everyday <input type="checkbox"/> Once a week <input type="checkbox"/> Only when necessary	Taken (check one) <input type="checkbox"/> With Food <input type="checkbox"/> Without Food	Times Taken (check all that apply) <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Supper <input type="checkbox"/> Just before bed <input type="checkbox"/> Right when woken up <input type="checkbox"/> When necessary
Additional Special Instructions		
Name of Medication		Amount Taken
How Often (check one) <input type="checkbox"/> Everyday <input type="checkbox"/> Once a week <input type="checkbox"/> Only when necessary	Taken (check one) <input type="checkbox"/> With Food <input type="checkbox"/> Without Food	Times Taken (check all that apply) <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Supper <input type="checkbox"/> Just before bed <input type="checkbox"/> Right when woken up <input type="checkbox"/> When necessary
Additional Special Instructions		
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Additional Special Instructions		