



# 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.																																																																																					
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Section 4 – Emergency Contact Information																																																																																													
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<p>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.</p>																																																																																													
<p>Please indicate either “YES” or “NO” that applies to your cadet for each condition below</p> <table style="width: 100%; border: none;"> <thead> <tr> <th style="width: 50%;"></th> <th style="text-align: center;">YES</th> <th style="text-align: center;">NO</th> <th style="width: 50%;"></th> <th style="text-align: center;">YES</th> <th style="text-align: center;">NO</th> </tr> </thead> <tbody> <tr> <td>Nervous trouble or breakdown</td> <td></td> <td></td> <td>Rheumatism or Arthritis</td> <td></td> <td></td> </tr> <tr> <td>Head injury, concussion, or headaches</td> <td></td> <td></td> <td>Stomach, bowel, or rectal problem</td> <td></td> <td></td> </tr> <tr> <td>Dizzy or fainting spells</td> <td></td> <td></td> <td>Hernia</td> <td></td> <td></td> </tr> <tr> <td>Convulsions or fits</td> <td></td> <td></td> <td>Low back pain</td> <td></td> <td></td> </tr> <tr> <td>Nose, throat, eye, or ear trouble</td> <td></td> <td></td> <td>Kidney or bladder trouble</td> <td></td> <td></td> </tr> <tr> <td>Diabetes</td> <td></td> <td></td> <td>Lung disease or chronic cough</td> <td></td> <td></td> </tr> <tr> <td>Skin conditions – medication</td> <td></td> <td></td> <td>Foot trouble</td> <td></td> <td></td> </tr> <tr> <td>Hives, hay fever, asthma, or allergy</td> <td></td> <td></td> <td>Motion or travel sickness</td> <td></td> <td></td> </tr> <tr> <td>Heart trouble, shortness of breath</td> <td></td> <td></td> <td>Broken bones</td> <td></td> <td></td> </tr> <tr> <td>Tropical diseases</td> <td></td> <td></td> <td>Learning disabilities (eg. Dyslexia)</td> <td></td> <td></td> </tr> <tr> <td>Color blindness</td> <td></td> <td></td> <td>Hearing loss or impairment</td> <td></td> <td></td> </tr> <tr> <td>Stuttering</td> <td></td> <td></td> <td>Bed wetting</td> <td></td> <td></td> </tr> <tr> <td>Wears corrective lens (Glasses/contacts)</td> <td></td> <td></td> <td>Menstrual problems producing disability</td> <td></td> <td></td> </tr> </tbody> </table>											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 (eg. Dyslexia)			Color blindness			Hearing loss or impairment			Stuttering			Bed wetting			Wears corrective lens (Glasses/contacts)			Menstrual problems producing disability		
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If you have checked "YES" to any of the above conditions, please give any additional information you feel is pertinent

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Describe any illnesses, injuries, or disabilities not previously listed

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

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List any operations in the last five (5) years

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Please describe any dietary restrictions

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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
		Child Dose	Adult Dose	Administer
<b>FOR PAIN</b>	Tylenol (acetaminophen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>FOR UPSET STOMACH</b>	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"/>
<b>FOR SOAR THROATS</b>	Lozenges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>SINUS CONGESTION</b>			
	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"/>
<b>FOR RASH OR INSECT BITES</b>	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"/>
<b>OTHER MEDICATION</b>		<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
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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
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## 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
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