

NEW ZEALAND CADET FORCES

COURSE NOMINATION AND MEDICAL HISTORY

1. PERSONAL DETAILS: Surname: _____ First names: _____ Date of birth: _____
 Rank: _____ Gender: _____ NZCF Unit: _____
 NZCF Service: _____ Years. _____ Months. Date of enrolment: _____ IRD No. (Staff): _____
 Street Address: _____
 Suburb: _____ City: _____ Postcode: _____
 Telephone No: Home: _____ Work: _____ Mobile: _____ Email: _____
 Age at start of course: _____ Years. _____ Months.

2. NEXT OF KIN:

Surname: _____ First names: _____ Relationship: _____
 Contact address for Next of Kin (for duration of course): _____
 Telephone No: Home: _____ Work: _____ Mobile: _____

3. ALTERNATE POINT OF CONTACT: (Different household from the Next of Kin)

Surname: _____ First names: _____ Relationship: _____
 Point of contact address for duration of course: _____
 Telephone No: Home: _____ Work: _____ Mobile: _____

4. COURSE DETAILS: Nominated as Staff Nominated as Student

Course: _____ Course dates: _____ Location: _____
 If nominated for other courses over the same period, list them: _____
 Course preference if accepted for multiple courses: _____
 If selected, request transport - From (town / city): _____ Return To (town / city): _____

5. PREVIOUS NZCF COURSES ATTENDED AS A STUDENT: (eg. Junior Leader / Outdoor Leader / Commissioning / IT)

Course	Date completed	Course	Date completed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6. CADET UNIT COMMANDER'S DECLARATION:

I, (full name) _____, certify that to the best of my knowledge, the information contained in this application is true and accurate. I also certify that to the best of my knowledge the applicant meets all eligibility criteria for this activity, if they do not, a letter requesting dispensation is attached.

I acknowledge that late, incomplete or ineligible nominations may result in the non-acceptance of this application.

The cadet unit order of priority for this application, against any other personnel nominated for this course from my cadet unit is:

Date: _____ Signature: _____

7. MEDICAL HISTORY, DIETARY REQUIREMENTS AND LEARNING ABILITY:

A. MEDICAL:

Name of family doctor, (or the doctor to be contacted in the event of a problem): _____

Doctor's telephone No: _____ Doctor's after hours contact: _____

Doctor's surgery address: _____

Do you currently have any **disease / sickness / injury / allergies / illness / disorder**? Yes No

Are you recovering from any **disease / sickness / injury / operation / illness / disorder**? Yes No

Are you currently receiving any medical treatment? Yes No

Are you taking any medication? Yes No

Have you had a reaction to any medical drugs used? Yes No

If the answer to any of the above questions is **YES**, or if there is any other medical information that may be relevant, please provide details.

1. Type and severity of injury / sickness / disease / operation / allergies / illness / disorder: _____

2. Restriction on activities: _____

3. Medication required (type, amount and frequency): _____

4. Medical drugs reacted to: _____

B. DIETARY: Please state any special dietary requirements (state exact requirements, attach to form if required):

C. LEARNING: Do you have a learning disability? Yes No Is a reader/writer required for examination? Yes No

8. PARENT / GUARDIAN DECLARATION FOR CADET UNDER 18 YEARS OF AGE:

I (full name) _____ accept responsibility for and may be required to repay any non refundable travel costs associated with the selection for this course should my son / daughter / ward voluntarily be removed for non compassionate reasons.

I further declare that the medical information provided above, to the best of my knowledge, is accurate and true and consent to my son / daughter / ward, participating in the course detailed above, which may include any of the following activities:

- | | | |
|-----------------------------------|---------------------------------|-------------------------------|
| Flying in military aircraft | Sailing / waterborne activities | Rifle safety / rifle shooting |
| Civil flying / Glider flying | Travel in military vehicles | Bushcraft |
| Sailing in naval / merchant ships | Team sports / Physical training | Drill |

I consent to my son / daughter / ward being treated by NZDF Medical Staff if required and accept responsibility to pay doctors fees or prescription charges, should this be necessary. I also consent to NZDF Medics providing initial assessment during authorised activities and on consultation with registered NZDF Medical staff, commence appropriate treatment as necessary.

Date: _____ Signature: _____

9. DECLARATION BY OFFICER OR CADET 18 YEARS OF AGE OR OVER:

I (full name) _____ accept responsibility and may be required to repay any non refundable travel costs associated with the selection for this course should I voluntarily be removed for non compassionate reasons.

I further declare that the medical information provided above, to the best of my knowledge, is accurate and true.

Date: _____ Signature: _____