THE NAVY LEAGUE OF CANADA

STAFF MEDICAL QUESTIONNAIRE

CONFIDENTIAL WHEN COMPLETED

Section 1 – Personal Information

Rank	Surname	Given Name	Middle Name(s)

Gender ☐Male ☐Female	Date of Birth (dd/mmm/yyyy)	Corps Number	Corps Name

Section 2 – Medical Information

Provincial Hospitalization/Insurance #	Expiry Date	Latest Tetanus Injection (Month/Year

Section 3 – Emergency Contact Information

Emergency Contact Name	Home Phone #
Relationship to Staff Member	Cell Phone #

The following information is requested to assist the Navy League Cadet Corps in determining the capabilities of the above-mentioned Staff. This information will NOT be used to stop you from joining nor stop any promotions.

Please indicate either **"YES"** or **"NO"** to the items below that apply to you

	YES	NO		YES	NO
Nervous trouble or mental health issues	☐	☐	Skin conditions requiring treatment	☐	☐
Anxiety / ADD / ADHD	☐	☐	Nose, throat, eye, or ear trouble	☐	☐
Learning disabilities (eg. Dyslexia)	☐	☐	Vision problems or Colour blindness	☐	☐
Heart problems, disease, defect	☐	☐	Hernia	☐	☐
Respiratory problems, shortness of breath	☐	☐	Hearing loss or impairment	☐	☐
Asthma, Bronchitis, Pneumonia	☐	☐	Rheumatism or Arthritis	☐	☐
Head injury, concussion, or stroke	☐	☐	Back, neck or joint pain	☐	☐
Convulsions or seizures	☐	☐	Foot trouble	☐	☐
Dizzy, fainting spells or headaches	☐	☐	Broken bones (past or current)	☐	☐
Diabetes	☐	☐	Previous surgeries (provide details)	☐	☐
Allergies (provide details/reaction/treatment)	☐	☐	Speech impediments (stuttering, etc)	☐	☐
Stomach, bowel or rectal problems	☐	☐	Motion or travel sickness	☐	☐
Kidney, bladder trouble or incontinence	☐	☐	Menstrual issues / problems	☐	☐
PTSD	☐	☐			
Wears corrective lens (Glasses/contacts)	☐	☐	Any other diseases, illnesses, problems not listed	☐	☐

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

Please describe any allergies (medications/food/Environmental including insect/bee stings) reactions/symptoms and treatments for the reactions. List all

Please describe any dietary restrictions

Please list any Religious or Cultural food Restrictions

Describe any Illnesses, injuries, or disabilities not previously listed

Signature	Date