



## STATEMENT OF MEDICAL FITNESS

### Navy League of Canada – Ontario Division

Corps Name and Number: \_\_\_\_\_

Surname		Given Name/Rank			
Address		Postal Code		Phone#	
Male <input type="checkbox"/>	Female <input type="checkbox"/>	Birth Date:		Religion	
Health Card#		Doctor's Name:			
Doctors Address:					
<b>EMERGENCY NOTIFICATION PRIMARY</b>					
NAME:			ADDRESS:		
PHONE:		CELL:	RELATIONSHIP:		
<b>EMERGENCY NOTIFICATION SECONDARY</b>					
NAME:			ADDRESS:		
PHONE:		CELL:	RELATIONSHIP:		
<b>HAS THE APPLICANT SUFFERED FROM ANY OF THE FOLLOWING?</b>					
	YES	NO		YES	NO
Nervous Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease or chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury or Concussion	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems causing disability	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy or Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever, Asthma or other Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Motion or Travel Sickness	<input type="checkbox"/>	<input type="checkbox"/>
Bed Wetting (at present)	<input type="checkbox"/>	<input type="checkbox"/>	Is the Applicant on a special diet	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Is the applicant on any medication now	<input type="checkbox"/>	<input type="checkbox"/>
Nose or Throat Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Medications	<input type="checkbox"/>	<input type="checkbox"/>
Ear Trouble or Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Lower Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Eye Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Other Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>
Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Other unusual Vital signs, e.g. slow pulse	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism or Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Foot Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble or shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	Stomach, bowel or rectal trouble	<input type="checkbox"/>	<input type="checkbox"/>
Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Illness or injuries not mentioned on this form	<input type="checkbox"/>	<input type="checkbox"/>
Any Recent operations	<input type="checkbox"/>	<input type="checkbox"/>	Are all vaccinations current	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered **YES** to any of the above illnesses, please provide details on a separate piece of paper (or use the reverse of this form). The information provided on this form will be kept in the strictest confidence. It is gathered to assist us or medical professionals in the case of an accident or illness.

I have completed this statement of medical fitness. I hereby certify that it reflects the actual medical fitness of the applicant. Further, I give permission for ANY medical facility to provide immediate emergency care to sustain life, limb or prevent disability to the applicant. I understand that I, or one of my emergency contacts listed above, will be notified as soon as possible following an accident or illness. Medications will be packed in a clear plastic (e.g. Tupperware) container.

DATE:.....Name: ..... Relationship .....

(please print)

Signature: .....