

**ADULT STAFF PERSONAL DETAILS AND CERTIFICATE OF  
HEALTH**

<b>Surname</b>		<b>Forenames</b>
<b>Rank</b>	<b>Service Number</b>	<b>ATC Sqn/ CCF Unit</b>

**NEXT OF KIN/PERSON TO CONTACT**

<b>Name</b>	<b>Relationship</b>
<b>Address</b>	<b>Telephone No</b>
<b><u>Post Code</u></b>	
<b>Contact address and telephone no during period of training (if different from above)</b>	

I have volunteered to take part in adventure training activities at:

\_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_

I certify that I am fit to participate in the activities and to take part in what may be strenuous pursuits. I will advise my Wing Administrative Officer if I have contact with any infectious diseases in the 3 weeks prior to the course.

The information contained in this document is classified as sensitive personal information and is subject to the provisions of the Data protection Act 1998. It is necessary for such information to be retained for legal reasons. Only such data as is relevant to your attendance on adventure training activities will be used/retained. Signing below indicates your consent for us to use and retain such data. You have the right under the Data Protection Act 1998 to request access to any personal information we hold about you.

Date \_\_\_\_\_ Signed \_\_\_\_\_

**REGARDLESS OF ANY MEDICAL CONDITION YOU ARE REQUESTED TO  
COMPLETE FULLY, INCLUDING DOCTOR'S DETAILS, AND SIGN THE  
CERTIFICATE OF HEALTH OVERLEAF AND TO ATTACH ANY NECESSARY  
DOCUMENTATION TO EXPLAIN IN DETAIL A CONDITION FROM WHICH YOU  
MAY SUFFER OR HAVE SUFFERED**

**SURNAME:** \_\_\_\_\_ **FORENAME(S):** \_\_\_\_\_

**CERTIFICATE OF HEALTH AND DECLARATION OF FITNESS**

**TO BE COMPLETED BY ALL CADETS AND ADULT STAFF**

\* **Note:** If any of the following do not apply insert “NONE” in the box(es).

1. **\*Medication.** I take the following medication:

Medication	Medical Condition

2.

Medical Condition/Past Injuries for which I do not take medication but may affect my performance during the activities.	Name, address and telephone number of the doctor I am registered with

3. **Asthma.** All cadets and adults must answer the following question:

Do you suffer or have you ever suffered from asthma? **YES/NO**

If **YES** then in addition to the declaration below you are to complete an Asthmatics Questionnaire and Declaration.

4. **Declaration.** I understand that I should be well prepared, physically and sufficiently fit to undergo strenuous activity. I have declared all medical matters that may affect my participation in the activities and I will inform the Officer in Charge of any additional medical matter that occurs after the date of signing this form.

**Signed:** .....

**Date:** .....

**SURNAME:** ----- **FORENAME(S):** -----

**ASTHMATICS QUESTIONNAIRE AND DECLARATION - TO BE COMPLETED  
BY ALL CADETS AND ADULT STAFF WHO SUFFER, OR HAVE SUFFERED,  
FROM ASTHMA**

\* Delete as appropriate

1. **Questionnaire.** I confirm that I **\*suffer/have suffered** from asthma and wish to declare the following information:

a. When was your last attack? .....

b. What preventative medication/inhalers do you use?(include strength and frequency of dose) .....

c. What reliever medication/inhalers do you use?:(include strength of dose)  
.....  
.....

Indicate frequency of use during normal daily activities eg once a day, once a week etc: .....

Indicate frequency of use during routine exercise .....

d. Have you ever required hospital admission for your asthma? **\*YES/NO.** If **YES** give details of when: .....

e. Have you sought advice from your doctor or asthma nurse prior to completing the health declaration? **\*YES/NO.** If **YES** what did your doctor or asthma nurse advise? .....

f. Any Additional Comments: .....

2. **Declaration.** I fully understand that adventure training is a strenuous activity, which may be undertaken in extremely cold and additionally, at times, in a “freezing fog” type atmosphere. Additionally, I confirm I have been advised that, if I am unsure about my fitness to take part in adventure training I should consult my Doctor or Asthma Nurse, before signing this Certificate and Declaration. Should my asthmatic condition change, requiring any amendment to the above questionnaire, before arriving for the activities, I undertake to advise the Officer in Charge, or if the change occurs during my participation in the activities.

**Signed:** ..... **Date:** .....