STATEMENT OF OFFICER MEDICAL FITNESS

Navy League of Canada-Ontario Division

ODI-2004

Corps Name: _____

Surname:	Given Name/Rank:	
Address:	Postal Code:	Phone#:
Male □ Female □	Birth Date:	Health Card#:
Doctor's Name:	Doctor's Telephone#:	
EMERGENCY NOTIFICATION PRIMARY		
Name:	Address:	
Phone:	Cell:	Relationship:
EMERGENCY NOTIFICATION SECONDARY		
Name:	Address:	
Phone:	Cell:	Relationship:
HAS THE APPLICANT SUFFERED FROM ANY OF THE FOLLOWING		

	YES	NO		YES	NO
Nervous Trouble			Lung Disease or chronic cough		
Head Injury or concussion			Menstrual problems causing disability		
Dizzy or fainting spells			Hay fever, asthma or other allergies		
Seizure disorders			Motion or travel sickness		
Is applicant on a special diet			Frequent headaches		
Is the applicant on any medication now			Nose or throat trouble		
Allergies to medication			Ear trouble or deafness		
Lower back pain			Eye trouble		
Other chronic pain			Food allergies		
High blood pressure			Kidney or bladder trouble		
Other unusual Vital signs, e.g. slow pulse			Diabetes		
Rheumatism or Rheumatic fever			Foot trouble		
Heart trouble or shortness of breath			Broken bones		
Stomach, bowel or rectal trouble			Skin conditions		
Medical alert bracelet/necklace /epi pens			Any recent operations		
Are all vaccinations current			Cancer treatments		

PLEASE LIST MEDICATIONS: (NOT ENOUGH ROOM PLEASE TURN OVER)

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 application. I understand that I, or one of my emergency contacts listed above, will be notified as soon as possible following an accident or illness.

Signature: _____ **Date:** _____