

**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 # (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: (Address must differ 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:  Student:

Course: \_\_\_\_\_ Course Dates: \_\_\_\_\_ Location: \_\_\_\_\_  
If nominated for other courses over the same period, list them: \_\_\_\_\_  
Course preference if accepted for multiple courses: \_\_\_\_\_

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

Course	Date Completed	Course	Date Completed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**6. CADET UNIT COMMANDER'S DECLARATION:**

I \_\_\_\_\_ certify that to the best of my knowledge, the information contained in this application is true. I understand that late and / or incomplete data may result in the non-acceptance of this application.

What priority does this application have in consideration with other personnel nominated from your Cadet Unit for this course?

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 \_\_\_\_\_ hereby consent to my son / daughter / ward, participating in the course detailed above, which may include any of the following activities:

Flying in military aircraft

Civil flying / Glider flying

Sailing in naval / merchant ships

Sailing / waterborne activities

Travel in military vehicles

Team sports / Physical training

Rifle safety / rifle shooting

Bushcraft

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) \_\_\_\_\_ declare that the medical information provided above to the best of my knowledge, is accurate and true.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_