

**NEW ZEALAND CADET FORCES**  
**COURSE NOMINATION AND MEDICAL HISTORY**

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**1. PERSONAL DETAILS:** Surname: \_\_\_\_\_ First names: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Rank: \_\_\_\_\_ Gender: \_\_\_\_\_ NZCF Unit: \_\_\_\_\_

NZCF Service: \_\_\_\_\_ Years. \_\_\_\_\_ Months. Date of enrolment: \_\_\_\_\_ IRD No. (Staff): \_\_\_\_\_

Street Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ City: \_\_\_\_\_ Postcode: \_\_\_\_\_

Telephone No: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

Age at start of course: \_\_\_\_\_ Years. \_\_\_\_\_ Months.

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**2. NEXT OF KIN:**

Surname: \_\_\_\_\_ First names: \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact address for Next of Kin (for duration of course): \_\_\_\_\_

Telephone No: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

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**3. ALTERNATE POINT OF CONTACT: (Different household from the Next of Kin)**

Surname: \_\_\_\_\_ First names: \_\_\_\_\_ Relationship: \_\_\_\_\_

Point of contact address for duration of course: \_\_\_\_\_

Telephone No: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

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**4. COURSE DETAILS:** Nominated as Staff  Nominated as Student

Course: \_\_\_\_\_ Course dates: \_\_\_\_\_ Location: \_\_\_\_\_

If nominated for other courses over the same period, list them: \_\_\_\_\_

Course preference if accepted for multiple courses: \_\_\_\_\_

If selected, request transport - From (town / city): \_\_\_\_\_ Return To (town / city): \_\_\_\_\_

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

Course	Date completed	Course	Date completed
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\_\_\_\_\_  
\_\_\_\_\_

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

I, (full name) \_\_\_\_\_, certify that to the best of my knowledge, the information contained in this application is true and accurate. I also certify that to the best of my knowledge the applicant meets all eligibility criteria for this activity, if they do not, a letter requesting dispensation is attached.

I acknowledge that late, incomplete or ineligible nominations may result in the non-acceptance of this application.

The cadet unit order of priority for this application, against any other personnel nominated for this course from my cadet unit is:

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

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

**MEDICAL - IN - CONFIDENCE**

**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: \_\_\_\_\_

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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 (full name) \_\_\_\_\_ accept responsibility for and may be required to repay any non refundable travel costs associated with the selection for this course should my son / daughter / ward voluntarily be removed for non compassionate reasons.

I further declare that the medical information provided above, to the best of my knowledge, is accurate and true and consent to my son / daughter / ward, participating in the course detailed above, which may include any of the following activities:

- |                                   |                                 |                               |
|-----------------------------------|---------------------------------|-------------------------------|
| Flying in military aircraft       | Sailing / waterborne activities | Rifle safety / rifle shooting |
| Civil flying / Glider flying      | Travel in military vehicles     | Bushcraft                     |
| Sailing in naval / merchant ships | Team sports / Physical training | 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:**

**MEDICAL - IN - CONFIDENCE**

I (full name) \_\_\_\_\_ accept responsibility and may be required to repay any non refundable travel costs associated with the selection for this course should I voluntarily be removed for non compassionate reasons.

I further declare that the medical information provided above, to the best of my knowledge, is accurate and true.

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

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