Updated October 2024

# BARBADOS CADET CORPS
# OFFICIAL CERTIFICATE OF MEDICAL FITNESS

**This form is fillable for Parents/Guardians - IF WRITTEN BY HAND – Use CAPITAL LETTERS.**
**DO NOT OMIT ANY DETAILS**

**Name of Child/Ward:** _____ Last Name _____ First Name _____ Middle Name

**Date of Birth** | | | | Day | Month | Year |

**Gender** ◯ Male ◯ Female

**Age** | |

**Blood Group** _____

**National Identification Number**
(Enter passport number if national ID # is not available)

| | | | | | | - | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |

**Name of school:** _____ **Company:** _____

**Please indicate if any of the items below are applicable to the cadet identified above.**
**-- This Certificate of Medical Fitness is void if any option below is not completed --**

| Complaint | YES | NO | Complaint | YES | NO |
|---|---|---|---|---|---|
| ADHD / ADD | ◯ | ◯ | Hearing Disorder | ◯ | ◯ |
| Allergies (Animals/Insects) | ◯ | ◯ | Heart Trouble | ◯ | ◯ |
| Allergies (Food) | ◯ | ◯ | High Blood Pressure | ◯ | ◯ |
| Allergies (Grass, Pollen etc.) | ◯ | ◯ | Hip Injuries or Strains | ◯ | ◯ |
| Allergies (Medicine) | ◯ | ◯ | Jaundice | ◯ | ◯ |
| Amnesia / Memory Loss | ◯ | ◯ | Kidney Problems/Disease | ◯ | ◯ |
| Anaemia | ◯ | ◯ | Knee / Ankle Injury | ◯ | ◯ |
| Anxiety Disorder / Nervousness | ◯ | ◯ | Lupus | ◯ | ◯ |
| Asthma | ◯ | ◯ | Mental Illness / Depression | ◯ | ◯ |
| Autism | ◯ | ◯ | Migraine | ◯ | ◯ |
| Back Injury / Lower back pain | ◯ | ◯ | Nervous System Disease | ◯ | ◯ |
| Broken / Fractured Bones | ◯ | ◯ | Past Surgery | ◯ | ◯ |
| Bronchitis | ◯ | ◯ | Pneumonia | ◯ | ◯ |
| Cancer | ◯ | ◯ | Rheumatism | ◯ | ◯ |
| Chest Pain | ◯ | ◯ | Shortness of Breath | ◯ | ◯ |
| Constipation | ◯ | ◯ | Sickle Cell Disease | ◯ | ◯ |
| Diabetes | ◯ | ◯ | Skin Disease (Rash, Eczema etc.) | ◯ | ◯ |
| Disease of the Blood | ◯ | ◯ | Sleeping Disorders | ◯ | ◯ |
| Dizziness or Fainting | ◯ | ◯ | Special Diet | ◯ | ◯ |
| Dyslexia | ◯ | ◯ | Speech Impediments | ◯ | ◯ |
| Ear / Nose / Throat / Sinus Problems | ◯ | ◯ | Stomach Disorders | ◯ | ◯ |
| Epilepsy / Fits / Seizures | ◯ | ◯ | Tuberculosis | ◯ | ◯ |
| Eye Disorder / Disease | ◯ | ◯ | Other Ailments / Illnesses (Give details under Additional Information) | ◯ | ◯ |
| Foot Disorders (e.g. Plantar Fasciitis) | ◯ | ◯ | | | |

**Sections below continue page 2 if needed**

**Additional Information** - If you have answered **"YES"** to any of the complaints listed above, **please give further details below**.

Please accurately list **ALL MEDICATIONS** that your child/ward currently uses.

_____ _____
_____ _____
_____ _____
_____ _____

**I, the undersigned parent/guardian give consent for my child/ward, identified overleaf, to receive counselling as deemed necessary: (tick below as appropriate)**

**YES** ☐ **NO** ☐ **INITIAL** _____

**I, the undersigned parent/guardian give consent for my child/ward, identified overleaf, to receive medical treatment as deemed necessary: (tick below as appropriate)**

**YES** ☐ **NO** ☐ **INITIAL** _____

**CONTACT INFORMATION**

**Name of Parent/Guardian** _____

**Address** _____

**Contact Information**

**Home Telephone** _____ **Work Telephone** _____ **Mobile Telephone** _____

**Other Contact Numbers** _____

**Email Address (List multiple, if applicable)** _____

**I, the undersigned, hereby affirm that the information provided on pages 1 and 2 of this Certificate of Medical Fitness is true and accurate. Additionally, I understand that if during the validity of this certificate of medical fitness my child sustains any injury or is involved in any accident, or, his/her medical condition is impacted by a diagnosis not listed on page 1, it is my duty to inform the Barbados Cadet Corps of such and have a new certificate of medical fitness issued and submitted to the Barbados Cadet Corps.**

**Name** _____

**Signature** _____

**Date** _____
DAY MONTH YEAR

# PHYSICIAN'S ASSESSMENT

**TO BE COMPLETED BY MEDICAL DOCTOR ONLY**

**IMPORTANT NOTE TO DOCTORS**

Cadet training and cadet camp involve strenuous activities such as running, hiking, carrying weight, crawling through undergrowth, bush and tall grass, standing for long periods of time, as well as remaining in wet clothing for extended periods of time. During exercises in the country, meals may be irregularly spaced. Cadets train in the midday sun. **Please bear these conditions in mind** when cadets present with what may seem trivial complaints.

Please give special consideration to such complaints as Asthma, Epilepsy, Heart Disease and Headaches / Migraines before declaring a child fit for cadet training. Hospital care can at times be more than an hour away. Please note that cadets should be deemed **MEDICALLY UNFIT** if the following conditions are present:

a. Severe fungal infection of feet, scalp or skin.
b. Migraines (severe in nature and long in duration), especially if induced by sunlight or hunger.
**c.** Uncontrolled or partially controlled Asthma; that is, frequent wheezing often requiring nebulization for symptom resolution. **(Please note that asthmatics who wheeze infrequently and whose bronchospasm is readily responsive to inhalers are permitted to attend training).**
d. Acute or recurrent lower back muscular strain, knee or ankle injuries etcetera.
e. Malignancies undergoing treatment.
f. Epilepsy resulting in the child having a seizure within the last twelve months.

**VITALS AT EXAMINATION DATE**

**BP** _____**/**_____ **mmHg** **HR** _____**bpm** **SpO2** _____**%**

Is the child identified (overleaf) and examined by you (undersigned physician) asthmatic? Tick appropriate box YES ☐ NO ☐

If "YES", does he/she require the use of inhalers? YES ☐ NO ☐ INITIAL ☐

I, the undersigned physician certify that _____
Cadet's Id# First Name Last Name

is **FIT / NOT FIT** to attend and participate in training and other activities with the Barbados Cadet Corps.

Remarks: (To include prescribed medication, pertinent notes on complaints noted overleaf, Details not included here should be submitted under separate cover for the **attention of Force Medical Officer, Barbados Defence Force.** If the child has been deemed unfit for training, please include details for such, and any necessary referrals/recommendations.)

## DETAILS AND STAMP OF MEDICAL PRACTITIONER

**Name** _____

**Signature** _____

**Date** _____
**DAY** **MONTH** **YEAR**

**AFFIX STAMP HERE**