

ANNEX B

INTERNATIONAL
AIR CADET EXCHANGE
INFORMATION FORM



IMPORTANT – IN CAPITAL LETTERS ONLY USING BLACK INK PLEASE

OWN COUNTRY:		YEAR OF EXCHANGE:	PHOTOGRAPH
FAMILY NAME (SURNAME) – ESCORTS INCLUDE MILITARY RANK WHERE HELD:			
GIVEN NAMES:			
NAME FOR NAME TAG: Nickname and surname			
FULL HOME ADDRESS (Including postal code/zip code):			
E-MAIL:			
CONTACT TELEPHONE NUMBERS		DAYTIME: OTHER:	PASSPORT NUMBER AND PLACE AND DATE OF ISSUE:
COUNTRY AND PLACE OF BIRTH:		DATE OF BIRTH:	
HOST COUNTRY:		LANGUAGES SPOKEN:	AGE AS OF 1 AUGUST OF THE EXCHANGE YEAR (cadets only):
<input type="checkbox"/> MALE	<input type="checkbox"/> AIR CADET	CADET AND CIVILIAN FLYING:	
<input type="checkbox"/> FEMALE	<input type="checkbox"/> ESCORT	<input type="checkbox"/> Flying Scholarship.	<input type="checkbox"/> Private Pilots Licence
		<input type="checkbox"/> Gliding Scholarship	<input type="checkbox"/> Glider Pilots Licence
		<input type="checkbox"/> Glider Instructor	<input type="checkbox"/> Other
DIETARY REQUIREMENTS (Nil or other):			
SPECIAL MEDICATION OR MEDICAL CONDITIONS: IE PREVIOUS MAJOR SURGERY, ASTHMA, HAY FEVER OR OTHER ALLERGIES(MEDICATION IS TO BE SPECIFIED):			
CONTACT IN CASE OF EMERGENCY:			
TELEPHONE NO: E-MAIL:		FAX/24 HOUR CONTACT NO:	
<p>CONSENT BY GUARDIAN OR PARENT RESPONSIBLE FOR CADETS UNDER 18 YEARS OF AGE: I give my permission for the cadet named above to fly in military and civilian aircraft during the International Air Cadet Exchange and to take part in the programmed activities of the host country. I also give permission for the cadet to be given any necessary surgical treatment during the Exchange</p> <p>SIGNED:</p> <p>DATE: PRINTED NAME:</p>			

ACF 13C (CADET) - CONSENT FORM AND CERTIFICATE OF HEALTH

To be completed and signed by the person having parental responsibility or personally by a cadet over 18 years old.

Cadet's Surname:		Forenames:
Rank:	Male/Female:	ATC Sqn/ CCF Unit:
Date of Birth:		Religion:
Next of Kin/ Person to Contact:	Nat Health Service No:	Relationship:
Home Address:		Telephone No:
Post Code:		
Contact address and telephone number during camp period (if different from above)		
Post Code:		
Summer*/Easter*/Overseas Camp*/Other Activity* (please specify) _____		
Dates:		* Please indicate camp or activity

Cadet Below the Age of 18	Cadet Over the Age of 18
I give full consent to the above named cadet to attend the camp or activity indicated above. I understand that he/she will be subject to RAF care and control and must conform to appearance standards required, especially hair length. Permission is given to participate in full training activities, including flying, swimming, shooting, using live ammunition, subject to medical conditions*. I give permission to the Camp Comdt or his appointed representative to act as the person in loco parentis should he/she have to undergo medical treatment including any emergency operation to which I am unable physically to give consent.	I understand that I will be subject to RAF care and control, during the camp or activity indicated above, and must conform to appearance standards required, especially hair length. I wish to participate in full training activities, including flying, swimming, shooting using live ammunition, subject to medical condition*
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 the cadet's attendance at the camp will be 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 on the cadet.	
Date _____ Signed _____	Date _____ Signed _____
Name in BLOCK Capitals _____	Name in BLOCK Capitals _____
(Person having Parental Responsibility)	(Cadet over the Age of 18)

*** If there is any doubt, a report from the cadet's doctor is required for consideration by the RAF medical authorities before a certificate to fly can be authorised.**

REGARDLESS OF THE CADET'S MEDICAL CONDITION YOU ARE REQUESTED TO COMPLETE FULLY AND SIGN THE CERTIFICATE OF HEALTH ON PAGE 4-D-7 AND TO ATTACH ANY NECESSARY DOCUMENTATION TO EXPLAIN IN DETAIL A CONDITION FROM WHICH A CADET MAY SUFFER OR HAVE SUFFERED

If you are in receipt of Income Support, Contribution-based Job Seekers Allowance or Family Credit you do not have to pay the food charge at Annual Camp. If you wish to claim exemption, please quote your Benefit Number in the box provided and sign below.

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Signed: _____

CERTIFICATE OF HEALTH

If the cadet suffers or has suffered from any of the following problems circle "YES" and add as much information as possible (you may attach the information in a separate envelope if you so wish but this form must be completed and signed). If none, circle "NO".

Chest and Heart Conditions. Other than mild chest infections, a chest or heart condition may be significant: this includes any history of asthma, bronchitis or wheezing Note: Asthma sufferers are to complete Asthmatic Medical and Consent Forms (ACP 237 Chap 4 Annex E) available from Wg HQ.	YES	NO
Epilepsy:	YES	NO
Any Loss of Consciousness or Blackouts: This includes any history of fainting episodes	YES	NO
Ear or Sinus Problems:	YES	NO
Diabetes:	YES	NO
Severe Headaches:	YES	NO
Any Other Major Illness or Injury:	YES	NO
Any Condition Requiring Regular Prescribed Medication:	YES	NO
Any Condition Requiring Regular Care, Doctor or Hospital Specialist:	YES	NO
Any Other Disability or pre-existing condition: (if YES give details)	YES	NO
Is the Cadet Taking Tablets or Medicines? (if YES, specify)	YES	NO
Does the Cadet have any known Allergies? (if YES, specify)	YES	NO
Does the Cadet have any Diet Restrictions or Special Food needs? (if YES, specify)	YES	NO

DETAILS OF CADET'S DOCTOR

NAME: _____

ADDRESS: _____

POST CODE: _____ TELEPHONE No: _____

DATE: _____ SIGNED: _____

NAME IN BLOCK CAPITALS: _____
 (Person having parental responsibility) (or cadet if aged 18 years or over)

RESTRICTED - MEDICAL
(when completed)

**ANNEX E TO
ACP 237 CHAP 4**

SURNAME: _____ **FORENAME(S)** _____

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

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 done): _____

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 annual camp activities can be a strenuous activity and consider that I am fit to attend camp.

Signed: _____ (cadet)

Date: _____

Countersigned: _____ (person having parental responsibility for a cadet under 18 years of age only)