KBA Training Centre Pte Ltd
A member of IRATA

Health Declaration Form

1. Your Details (please use block letters)

Please Circle	Surname	Given Name
Mr. Mrs. Ms. Miss		

Date of birth: | | | | | | | |

Full Postal Address

Country: Postal Code:

2. Emergency Contacts

Name	Contact Number	Relationship

3. Medical History

Have you ever suffered or been treated by any of the following conditions? Please tick where appropriate.

- ☐ Respiratory Conditions (eg. asthma)
- ☐ Heart Problems (eg. Angina)
- ☐ Circulatory Conditions (eg. Thrombosis)
- ☐ Epilepsy
- ☐ Gynaecological Disorders
- ☐ High Blood Pressure
- ☐ Any other conditions
- ☐ Diabetes
- ☐ Back, Neck or Shoulder Problems
- ☐ Physical Disability
- ☐ Mental Disability
- ☐ Balance and dizziness disorders
- ☐ Acrophobia (fear of heights)
- ☐ Any transmittable infection or been to an outbreak area in the last 10 days.

4. Please give further details of condition(s) if any, including last treatment date and by whom.

5. Declaration

By signing below, I agree that I am in good condition physically and mentally to undergo the training and assessment. I declare that all the information included is accurate, true and complete to the best of my knowledge and belief.

Signature: _____ Date: _____

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