

MINISTRY OF YOUTH AND SPORTS

1. CHILD

Last name : _____ First name : _____

Date of birth : __ / __ / ____

Boy

Girl

This form collects useful information during the child's stay; she avoids depriving you of her health book. It will be destroyed in 2020. Please inform us of any changes during your stay.

2. VACCINATIONS

(refer to the child's health record or vaccination certificates)

COMPULSORY VACCINES	DATES OF LAST RECALLS	RECOMMENDED VACCINES	DATES
Diphtheria		Hepatitis B	
Tetanus		Rubella Mumps Measles	
Poliomyelitis		whooping cough	
Or DT polio		BCG	
Or Tétracoq		Others (specify)	

If the child does not have the compulsory vaccines, attach a medical certificate of contraindication. Please note: the tetanus vaccine has no contraindications.

3. MEDICAL INFORMATION ABOUT THE CHILD

Does the child receive **medical treatment** during the stay ?

Yes

No

If yes, attach a recent **prescription** and the corresponding **medicines (boxes of medicines in their original packaging marked with the child's name along with the leaflet)**.

No medication can be taken without a prescription.

Has the child ever had the following illnesses?

RUBELLA	VARICELLA	ANGINA	MUMPS	SCARLET FEVER
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

COQUELUCHE	OTITIS	MEASLES	ACUTE ARTICULAR RHUMATISM
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Allergies :

ASTHMA <input type="checkbox"/> Yes <input type="checkbox"/> No	FOOD <input type="checkbox"/> Yes <input type="checkbox"/> No	DRUGS <input type="checkbox"/> Yes <input type="checkbox"/> No	OTHERS :
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Specify the cause of the allergy and the course of action (if self-medication report it) :

In case of diet, specify :

- WITHOUT MEAT**
- WITHOUT PIG**

Indicate below :

Health difficulties (illness, accident, specific behavior, seizures, hospitalization, operation, rehabilitation) specifying the dates and the precautions to be taken.

Helpful parent recommendations :

Does your child wear glasses, contact lens, hearing aids, dentures, etc. Specify.

SWIMMING :

- KNOWS TO SWIM**
- Manages**
- CANNOT SWIM**

Various comments :

4. RESPONSIBLE FOR THE CHILD

Last name : _____ First name : _____

Address : _____

Phone number

Mother : _____ Father : _____

I, the undersigned _____ declares that the information on this sheet is accurate and authorizes the person responsible for the stay to take, if necessary, all measures (medical treatment, hospitalization, surgical intervention) made necessary by the child's condition. I also authorize, if necessary, the stay director to remove my child from the hospital after hospitalization.

Doctor's child : _____

Name : _____ Tel : _____

Date : _____ Signature: _____