FRENCH 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 after child's stay. Please inform us of any changes during your stay.

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

COMPULSORY VACCINES	**YES or NO**	**DATES OF LAST RECALLS**	**RECOMMENDED VACCINES**	**DATES**
Diphtheria			Hepatitis B	
Tetanus			Rubella Mumps Measles	
Poliomyelitis			whooping cough	
Or DT polio			BCG	
Or Tetracoq			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
❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

COQUELUCHE	OTI TIS	MEASLES	ACUTE ARTICULAR RHUMATISM
❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

Allergies :

ASTHMA ❑ Yes ❑ No	**FOOD** ❑ Yes ❑ No	**DRUGS** ❑ Yes ❑ No	**OTHERS** :

Specify the cause of the allergy and the course of action (if self-medication report it) :

_____

_____

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.

_____

_____

4. RESPONSIBLE FOR THE CHILD

Last name :_____First name : _____

I, the undersigned_____responsible for the child, 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 (optional) : Name :_____Tel : _____

Date : Signature: