MEDICAL FORM
AND DISCHARGE OF RESPONSIBILITY

This form is destined to collect useful medical information about your child:

Surname (child):
First name (child):
Date of birth: Male [ ] Female [ ]

Address: Town:
Post code:
Country:

Phone number:
Mobile phone number (mother):
Mobile phone number (father):
E-mail:

Responsible people for the children
Name / First name (mother):
Name / First name (father):

Vaccination

Please fill in compliance with health record

Mention if this is: **COMPULSORY VACCINES** DATES

Diphteria ……………………………………………………………………………………./……/………………
Tetanus ……………………………………………………………………………………./……/………………
Polio or DT Polio ……………………………………………………………………………./……/………………
Or Tetracoq ………………………………………………………. ……………………./……/………………
1st BCG vaccine ………………………………………………………………………../……/………………
BCG revaccination……………………………………………………………………../……/………………..

RECOMMENDED VACCINES

Hepatitis B ……………………………………………………………………………./……/………………
Rubella-mumps-measles ……………………………………………………………../……/………………
Pertussis………………………………………………………………………………../……/………………
Other ………………………………………………………………………………………../……/………………

In case the child is not vaccinated, please show a contraindication medical certificate.

Did your child have the following diseases? (Please circle the answer)

Rubella	**Varicella**	**Angina**	**Rheumatism**	**Scarlatina**
Yes No	Yes No	Yes No	Yes No	Yes No

Pertussis	**Otitis**	**Asthma**	**Measles**	**Mumps**
Yes No	Yes No	Yes No	Yes No	Yes No

Or allergies ?

Asthma	**Food**	**Medicines**	**Other**
Yes No	Yes No	Yes No	Yes No

Specify the origin of the allergy and how to behave (if self-medication, specify it)

If there are other medical problems, please list them and mention which precautions should be taken? (Disease, accidents, convulsive crises, hospitalization, surgeries, physiotherapy...)

Currently, is your child following a course of treatment?

Please specify which treatment and provide a recent prescription and the corresponding medicines (medicines must be stored in their original packages with the name of your child written on the leaflet). No medicine can be given without prescription.

Useful recommendations given by parents

Could you please mention if your child wears any contact lenses, glasses or has any hearing aid, prosthodontics, etc.

Discharge of responsibility

I, the undersigned, , as the person legally in charge of the child, do declare that the information given on this form are true and I allow Surftraining manager, if need be, to take all the necessary measures justified by my child's state of health (medical treatments, hospitalization, surgery, blood transfusion).

Date: Signature: