

MEDICAL FORM 2018-2019

I/ We the undersigned (name of parent(s)/guardian(s))

.....
give our consent to the teachers employed by *Section Internationale, La Celle St Cloud-Noisy le Roi* to take the necessary action and seek appropriate medical care (including hospitalisation in case of emergency).

First name and surname of child:

Name of the family doctor:

Telephone number of the family doctor:

Name of the paediatrician:

Telephone number of the paediatrician:

Name of the Health Care insurance provider:

Number of the Health care insurance policy:

Known allergies to the following medicines / foods:

In..... on

Signature of the parent(s):

.....

Please contact me at the following number:

If you cannot reach me, please contact:

Name:

Relation (family, friend, neighbour):

Telephone number:

Name:

Relation (family, friend, neighbour):

Telephone number: