MINISTER DE LA JEUNESSE ET DES SPORTS

cerfa

HEALTH FORM OF DEPENDANT

THIS FORM HAS BEEN DESIGNED TO GATHER MEDICAL INFORMATION WHICH MAY BE USEFUL DURING YOUR CHILD'S STAY. THIS PREVENTS YOU FROM HAVING TO PART WITH HIS/HER MEDICAL/HEALTH RECORDS. THIS FORM WILL BE GIVEN BACK TO YOU AT THE END OF THE STAY, POSSIBLY INCLUDING SOME OBSERVATIONS.

I. **CHILD:** LAST NAME:_____ 1st NAME :_____

SEX : BOY ☐ GIRL ☐ DATE OF BIRTH : ___/___/___ dd mm yy

II. VACCINATIONS (*Fill out from your child's medical records or vaccination certificate AND include photocopies from your child's medical shot records.*)

POLIO – DIPTHERIA – TETANUS- WHOOPING COUGH

Specifiy whether it is:	VACCINATIONS GIVEN	DATES
Diphtheria Tetanus Polio vaccination		
Diphtheria Tetanus Whooping-cough vaccination		
Diphtheria Tetanus Whooping-cough polio update vaccination		
updated polio vaccination		
Hepatitise B vaccination		
BOOSTERS		

TUBERCULOSIS	DATES	SMALLPOX	DATES	OTHER VACCIANTIONS	VACCINATIONS GIVEN	DATES
1st VACCIN TION		VACCINE				
2nd VACCINATION		1st BOOSTER				

IF YOUR CHILD HAS NOT BEEN VACCINATED,
WHY ? _____

	TYPE	DATES
SERUM INJECTIONS		

III. MEDICAL INFORMATION ABOUT YOUR CHILD

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING SICKNESSES :

GERMAN MEASLES		CHICKENPOX		TONSILLITIS		RHEUMATISM		SCARLET FEVER	
NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐
WHOOPING COUGH		**EAR INFECTION**		**ASTHMA**		**MEASLES**		**MUMPS**	
NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐

INDIQUATE HERE OTHER HEALTH PROBLEMS, SPECIFYING THE DATES : (sicknesses, accidents, convulsions, allergies, hospitalizations, operations, rehabilitations)	

IV. RECOMMANDATIONS OF THE PARENTS

IS YOUR CHILD CURRENTLY UNDERGOING ANY MEDICAL TREATMENT? NO ☐ YES ☐

IF YES, WHAT KIND? _____

IF YOUR CHILD MUST UNDERGO A MEDICAL TREATMENT DURING HIS/HER STAY, DON'T FORGET TO INCLUDE THE PRESCRIPTION FOR HIS/HER MEDICINE

DOES YOUR CHILD WET HIS/HER BED ? NO ☐ OCCASIONALLY ☐ YES ☐

IF YOUR CHILD IS A GIRL, HAS SHE HAD HER 1ST MENSTRUAL CYCLE? NO ☐ YES ☐

V. PERSON RESPONSABLE FOR THE CHILD:

LAST NAME: _____ FIRST & MIDDLE NAMES: _____

YOUR ADDRESS (DURING THE TIME OF THE CHILD'S STAY): _____

		HOME	OFFICE
SS #		TEL #.	

ADDRESS OF MEDICAL INSURER: _____

I the undersigned, responsible for the child, declare all information provided on this form to be correct, and I authorize the persons in charge of the stay, if need be, to take all measures (medical treatments, hospitalizations, surgical interventions) made necessary by the condition of the child.

Date : Signature :

PART RESERVED FOR CAMP ORGANIZER

PLACE OF STAY :

Organization's Seal/Stamp (head office)

ARRIVAL

DEPARTURE

OBSERVATIONS DURING THE COURSE OF THE CHILD'S STAY

BY THE DOCTOR ☐ (who will note his name, address and telephone #)

BY PERSON IN CHARGE OF THE STAY ☐ (who will note his name and address)