

# INFORMATIONS MÉDICALES

## MEDICAL INFORMATION

<b>ENFANT / CHILDREN</b>				
Nom / Surname :	Prénom / Christian name	Date de naissance Date of Birth	Sexe M / F <input type="checkbox"/> <input type="checkbox"/>	Nom de l'assurance maladie et accident Medical + accident insurance details <input type="checkbox"/> L'assurance du Pré-fleuri OKK <input type="checkbox"/> Autre _____

<b>ANAMNESE PERSONNELLE / MEDICAL HISTORY</b>																																																																																											
<b>GROUPE SANGUIN:</b> <input style="width: 100%;" type="text"/>  <b>ALLERGIES:</b> <input type="checkbox"/> Non <input type="checkbox"/> Oui <input style="width: 100%;" type="text"/>  <b>OPERATIONS:</b> <input type="checkbox"/> Non <input type="checkbox"/> Oui <input style="width: 100%;" type="text"/>  <b>LESIONS ANTERIEURES:</b> <input type="checkbox"/> Non <input type="checkbox"/> Oui <input style="width: 100%;" type="text"/>  <b>TRAITEMENT EN COURS:</b> <input type="checkbox"/> Non <input type="checkbox"/> Oui <input style="width: 100%;" type="text"/>  <b>MALADIES:</b> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;"></th> <th style="width: 10%;"></th> <th style="width: 10%;"></th> <th style="width: 15%;"></th> <th style="width: 50%; text-align: center;">Date du vaccin / Rappel</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Non</td> <td><input type="checkbox"/> Oui</td> <td></td> <td>Varicelle</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Non</td> <td><input type="checkbox"/> Oui</td> <td></td> <td>Rougeole</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Non</td> <td><input type="checkbox"/> Oui</td> <td></td> <td>Rubéole</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Non</td> <td><input type="checkbox"/> Oui</td> <td></td> <td>Oreillons</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Non</td> <td><input type="checkbox"/> Oui</td> <td></td> <td>Scarlatine</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Non</td> <td><input type="checkbox"/> Oui</td> <td></td> <td>Hépatite</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Non</td> <td><input type="checkbox"/> Oui</td> <td></td> <td>Autre</td> <td>_____</td> </tr> <tr> <td></td> <td></td> <td></td> <td>Tétanos</td> <td>_____</td> </tr> </tbody> </table>					Date du vaccin / Rappel	<input type="checkbox"/> Non	<input type="checkbox"/> Oui		Varicelle	_____	<input type="checkbox"/> Non	<input type="checkbox"/> Oui		Rougeole	_____	<input type="checkbox"/> Non	<input type="checkbox"/> Oui		Rubéole	_____	<input type="checkbox"/> Non	<input type="checkbox"/> Oui		Oreillons	_____	<input type="checkbox"/> Non	<input type="checkbox"/> Oui		Scarlatine	_____	<input type="checkbox"/> Non	<input type="checkbox"/> Oui		Hépatite	_____	<input type="checkbox"/> Non	<input type="checkbox"/> Oui		Autre	_____				Tétanos	_____	<b>BLOOD GROUP</b> <input style="width: 100%;" type="text"/>  <b>ALLERGIES:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input style="width: 100%;" type="text"/>  <b>OPERATIONS:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input style="width: 100%;" type="text"/>  <b>FORMER INJURIES:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input style="width: 100%;" type="text"/>  <b>TREATMENT IN PROGRESS:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input style="width: 100%;" type="text"/>  <b>MALADIES:</b> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;"></th> <th style="width: 10%;"></th> <th style="width: 10%;"></th> <th style="width: 15%;"></th> <th style="width: 50%; text-align: center;">Last booster date</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes</td> <td></td> <td>Chicken pox</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes</td> <td></td> <td>Measles</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes</td> <td></td> <td>german measles</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes</td> <td></td> <td>Mumps</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes</td> <td></td> <td>Scarlet fever</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes</td> <td></td> <td>Hepatitis</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes</td> <td></td> <td>Other</td> <td>_____</td> </tr> <tr> <td></td> <td></td> <td></td> <td>Tetanus</td> <td>_____</td> </tr> </tbody> </table>					Last booster date	<input type="checkbox"/> No	<input type="checkbox"/> Yes		Chicken pox	_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes		Measles	_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes		german measles	_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes		Mumps	_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes		Scarlet fever	_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes		Hepatitis	_____	<input type="checkbox"/> No	<input type="checkbox"/> Yes		Other	_____				Tetanus	_____
				Date du vaccin / Rappel																																																																																							
<input type="checkbox"/> Non	<input type="checkbox"/> Oui		Varicelle	_____																																																																																							
<input type="checkbox"/> Non	<input type="checkbox"/> Oui		Rougeole	_____																																																																																							
<input type="checkbox"/> Non	<input type="checkbox"/> Oui		Rubéole	_____																																																																																							
<input type="checkbox"/> Non	<input type="checkbox"/> Oui		Oreillons	_____																																																																																							
<input type="checkbox"/> Non	<input type="checkbox"/> Oui		Scarlatine	_____																																																																																							
<input type="checkbox"/> Non	<input type="checkbox"/> Oui		Hépatite	_____																																																																																							
<input type="checkbox"/> Non	<input type="checkbox"/> Oui		Autre	_____																																																																																							
			Tétanos	_____																																																																																							
				Last booster date																																																																																							
<input type="checkbox"/> No	<input type="checkbox"/> Yes		Chicken pox	_____																																																																																							
<input type="checkbox"/> No	<input type="checkbox"/> Yes		Measles	_____																																																																																							
<input type="checkbox"/> No	<input type="checkbox"/> Yes		german measles	_____																																																																																							
<input type="checkbox"/> No	<input type="checkbox"/> Yes		Mumps	_____																																																																																							
<input type="checkbox"/> No	<input type="checkbox"/> Yes		Scarlet fever	_____																																																																																							
<input type="checkbox"/> No	<input type="checkbox"/> Yes		Hepatitis	_____																																																																																							
<input type="checkbox"/> No	<input type="checkbox"/> Yes		Other	_____																																																																																							
			Tetanus	_____																																																																																							
<b>REMARQUE:</b> <input type="checkbox"/> Non <input type="checkbox"/> Oui <input style="width: 100%;" type="text"/>	<b>NOTICE:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input style="width: 100%;" type="text"/>																																																																																										

<b>INFORMATIONS ALIMENTAIRES / DIETARY REQUIREMENTS</b>	
<b>REGIME ALIMENTAIRE:</b> <input type="checkbox"/> Sans porc <input type="checkbox"/> Selon indication médicale _____ <input type="checkbox"/> Allergies _____ <input type="checkbox"/> Autre _____	<b>SPECIAL DIET:</b> <input type="checkbox"/> No pork <input type="checkbox"/> Medical condition _____ <input type="checkbox"/> Allergies _____ <input type="checkbox"/> Other _____

