

INFORMATIONS MEDICALES



ENFANT / CHILDREN

Nom / Surname :	Prénom / 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 Swisscare <input type="checkbox"/> Autre _____
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ANAMNESE PERSONNELLE / MEDICAL HISTORY

GROUPE SANGUIN: _____	BLOOD GROUP _____
ALLERGIES: <input type="checkbox"/> Non <input type="checkbox"/> Oui _____ _____	ALLERGIES: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ _____
OPERATIONS: <input type="checkbox"/> Non <input type="checkbox"/> Oui _____ _____	OPERATIONS: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ _____
LESIONS ANTERIEURES: <input type="checkbox"/> Non <input type="checkbox"/> Oui _____ _____	FORMER INJURIES: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ _____
TRAITEMENT EN COURS: <input type="checkbox"/> Non <input type="checkbox"/> Oui _____ _____	TREATMENT IN PROGRESS: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ _____
MALADIES : <input type="checkbox"/> Non <input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Oui	Date du vaccin / Rappel Varicelle _____ Rougeole _____ Rubéole _____ Oreillons _____ Scarlatine _____ Hépatite _____ Autre _____ Tétanos _____
REMARQUE: <input type="checkbox"/> Non <input type="checkbox"/> Oui _____ _____	ILLNESSES : <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes
	Last booster date Chicken pox _____ Measles _____ German measles _____ Mumps _____ Scarlet fever _____ Hepatitis _____ Other _____ Tetanus _____
	NOTICE: <input type="checkbox"/> No <input type="checkbox"/> Yes _____ _____

INFORMATIONS ALIMENTAIRES / DIETARY REQUIREMENTS

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