

MEDICAL INFORMATION



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"/> Pré-fleuri Insurance : Swisscare <input type="checkbox"/> Other _____ |
|-----------------|---------------|------------------------------------|--|---|

ANAMNESE PERSONNELLE / MEDICAL HISTORY

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|---|--|
| 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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