CONFIDENTIAL HEALTH INFORMATION FILE

**Surname(s) and first name(s) of the student** …………………………………………………………………………………..............

**Date of birth**: ……/……/……

# Legal guardians

Surnames, first names:

1. …………………………………………………………………………………………………………………………………………

2. ……………………………………………………………………………………………………………………………………….

# Accommodation address:

…………………………………………………………………………………………………………………………………………………………………………

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**Legal guardians’ phone numbers**: ……………………………………………………………………………………………….

………………………………………………………………………………………………

**Phone number of a trusted person to contact if necessary**:  ………………………………………………………

## Vaccines: (if possible, attach a copy of the vaccination certificate)

|  |  |  |
| --- | --- | --- |
| VACCIN | Nombre d’injections reçues | Dates |
| Diphtheria (diphtheria) |  |  |
| Tetanus (tetanus) |  |  |
| Poliomyelitis (polyomielitis) |  |  |
| Whooping cough (pertussis) |  |  |
| Hib (haemophilus) |  |  |
| Rubella (rubella) |  |  |
| Mumps (mumps) |  |  |
| Measles (measles) |  |  |
| Hepatitis B (hepatitis) |  |  |
| Meningitis (meningitis) |  |  |
| Pneumococcus (Pneumococcus) |  |  |
| BCG (tuberculosis) |  |  |
| COVID 19 |  |  |

**Diseases**: (circle **yes** or **no**)

|  |  |  |  |
| --- | --- | --- | --- |
| **Allergies*** **Food allergies**
* **Respiratory allergies**
* **Skin allergies**
 | Yes Yes YesYes | No No NoNo | If yes : specify whichTreatment: |
| **Asthma** | Yes | No | If yes, treatment: |

|  |  |  |  |
| --- | --- | --- | --- |
| **Urticaria eczema** | Yes | No |  |
| **Epilepsy** | Yes | No | If yes, treatment: |
| **Back problems, scoliosis or other** | Yes | No | If yes, specify: |
| **Other osteoarticular disease, shoulders,****knees, ankles ...** | Yes | No | If yes, treatment: |
| **Eye problems** | Yes | No | Corrections (glasses, contact lenses) :Yes No |
| **Hearing problems** | Yes | No | Hearing aid: Yes No |
| **Heart** | Yes | No | If yes, specify:Treatment : |

# Any pathologies or diseases, accidents that you think important to inform us of:

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# Current monitoring:

* Did he/she benefit from some psychological supervision in your country Yes No
* Did he/she benefit from some medical supervision in your country Yes No

Specify…………………………………………………………………………………………………………………………………………

* Does he/she currently have a medical treatment Yes No Specify…………………………………………………………………………………………………………………………………………
* Other types of monitoring Yes No Specify ……………………………………………………………………….
* Hospitalisation(s) Yes No When:

Specify the reason: …………………………………………………………………………………………

# Information: In the event of an emergency, an injured or ill student is referred and transported by the emergency services to the most appropriate hospital or care service, as determined by the “SAMU-Centre. 15”. Parents or legal guardians are immediately notified by the school. A minor student may not leave the hospital or the care unit without being accompanied by one of his parents or his legal guardian

**Place …………………………………………………………………… Date ………………………………………………………**

**Signatures of the legal guardian(s)**