



Mail: 1334 Walnut St, 6th Floor
Philadelphia, PA 19107
Fax: 215-751-1986
Tel: 800-879-6640/215-751-1100
Email: info@amerispan.com
Web: http://www.amerispan.com

Monte Carlo, Monaco Residential Summer Camp

Medical release- Going out Permission

Dear parents,

*Would you please fill in and sign this form and return to AmeriSpan, the information detailed below will then be conveyed to the **Centre Méditerranéen d'Etudes Françaises**.*

<p style="text-align: center;">HEALTH INFORMATION FORM</p>

<p style="text-align: center;"><i>This form has to be duly filled and sent back together with the enrolment form</i></p>
--

THIS FORM IS TO GET INFORMATION THAT IS USEFUL DURING THE STAY OF THE CHILD

DATE AND PLACE OF THE STAY _____

1 – PERSONAL DETAILS

SURNAME _____

FIRST NAME: _____

DATE OF BIRTH: _____

2 – VACCINATIONS

COMPULSORY VACCINES

Diphtheria

Anti –Tetanus

OTHERS (state clearly) _____

3 – MEDICAL INFORMATION CONCERNING THE CHILD

Is the child under **medical treatment** during the stay? Yes No

If yes please attach a recent prescription and the corresponding medication (medication in their original packaging with the name of the child and instructions)

ALLERGIES:

ASTHMA _____

FOOD _____

MEDICATION _____

OTHERS _____

STATE THE CAUSE OR THE ALLERGY AND WHAT TO DO (point out if the child takes his/her own medication)

STATE HEALTH PROBLEMS (ILLNESS, ACCIDENT, CONVULSIVE ATTACKS, HOSPITALIZATION, OPERATION, PHYSIOTHERAPY) PRECISING THE DATES AND PRECAUTIONS TO TAKE.

4 – PARENTS’ USEFUL RECOMMENDATIONS

DOES YOUR CHILD WEAR CONTACT LENSES, SPECTACLES, HEARING AID, DENTURE, ETC...STATE CLEARLY.

5 – PERSON RESPONSIBLE FOR THE CHILD

SURNAME _____ FIRST NAME _____

ADDRESS (DURING THE STAY) _____

TELEPHONE: (HOME and MOBILE) _____

OFFICE: _____

NAME AND TEL.N° OF THE CHILD’S DOCTOR (OPTIONAL) _____

6- GOING OUT PERMISSION

I give permission to my son / my daughter

to go out alone until 07.00 p.m.

During this time, the Centre Méditerranéen is not responsible for him / her.

I,..... responsible for the child declare that the information in this form is true and authorize the director of the school to take any important measures (medical treatment, hospitalization, operation) for the child’s state of health if need be.

Signature: _____ Date: _____