**Medical Sheet**

**This medical form must provide all relevant information from participants. Thank you for sending us this information at least four weeks before the start of the activity.**

**The Participant**

Name : ……………………………….… 1st Name: ……………………………..… Birth date:

Address :

Blood Group : ………………………… Weight:………………………… Height : ………………………… Shoe size :

Mother tongue? ……………………………………….

Doctor’s name :

Address :

Phone :

**Please join to this document a copy of the European Health Insurance Card (for European volunteers only).**

**EMERGENCY CONTACT PEOPLE**

Name : ………………………………………………... Relation : ………………………………. Phone :

Name : ………………………………………………... Relation : ………………………………. Phone :

3rd person to contact if the two first are unreachable:

Name : ………………………………………………... Relation : ………………………………. Phone :

**FOOD**

Is the participant following a special diet (allergies, intolerances, vegetarian, pork-free diet, ...)?

 □ Yes □ No

If Yes, please give us more details :

**LEISURES**

1. What are the hobbies/leisure activities of the participant?

1. Can (s)he read & write ?

|  |  |  |  |
| --- | --- | --- | --- |
| □ Very well | □ well | □ With difficulty | □ Not at all |

1. Can (s)he swim ?

|  |  |  |  |
| --- | --- | --- | --- |
| □ Very well | □ well | □ With difficulty | □ Not at all |

1. Can (s)he ride a bike ?

|  |  |  |  |
| --- | --- | --- | --- |
| □ Very well | □ well | □ With difficulty | □ Not at all |

Is there any activities in which the participant can’t participate? Thank to specify the reason (s)

.

**Health and medical information**

1. Did (s)he go through a serious disease or a serious medical operation ? □ Yes □ No

If yes, please give more details ( what kind of disease or operation, when…)

1. Is (s)he vaccinated against tetanus ? □ Yes □ No

1st vaccination ‘s date :

Last vaccination ’s date:

1. Is (s)he allergic to?
* Any medicine ? □ Yes □ No

If yes, wich ?

* Sun ? □ Yes □ No

If yes ? What precautions should be taken?

* Other ? □ Yes □ No

If yes, what exactly?

1. Does (s)he have to take medication during his/her stay ? □ Yes □ No

If yes, which ones ?

1. Can (s)he take his/her medication alone ? □ Yes □ No
2. Does (s)he wear glasses or lentils? Which diopter
3. Does (s)he have any prosthesis ?

|  |  |  |
| --- | --- | --- |
|  | □ Hearing aid | □ Denture |
|  | □ Pace maker | □ other : ……………………………………….. |

1. Does (s)he have a disability? □ Yes □ No

|  |  |
| --- | --- |
| □ Mental disability…………………………………………………. | □ Physical disabilty……………………………………………………………….. |
| □ Visual impairment |  |
| □ Hearing impairment  |  |

1. Does the participant suffers (permanently or regularly) from :

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | If YES, what is the usual treatment? How to react? What special precautions do we have to take? Thank to complete if necessary  |
| Diabetes |  |  |  |
| Heart problem |  |  |  |
| Epilepsy |  |  |  |
| Skin disease |  |  |  |
| Somnambulism |  |  |  |
| Insomnia |  |  |  |
| Incontinence(day or night) |  |  |  |
| Contagious disease |  |  |  |
| Asthma |  |  |  |
| Headache |  |  |  |
| Other |  |  |  |

**I, the undersigned certify the accuracy of the information contained in this sheet and allow the people in charge of the activity, to decide, by a qualified medical personnel, any action (medical treatment, hospitalization, surgical operation, ...) necessitated by the state of the participant.**

Name of signatory and function (parent / guardian-tutor/participant over 18 Y.o. )

Date : Signature