MEDICAL FORM
ERASMUS+/SEMESTER EXCHANGE

Last name: **First name:**

Date of birth:
Current mailing address:
Primary telephone: Mobile/cell phone:
Email address:

Emergency contact/next of kin

Please provide details of the relative or person we can contact in case of emergency when you are in France

Ms ☐Mr ☐ Relationship to you:
Address (if different from yours):
Primary telephone: Mobile/cell phone:
Email address:

Health record and vaccinations

Please join a copy of your health record with up-to-date vaccinations
As you are required to eat at the school refectory, kindly inform of any known medical problems or allergies:
Any dietary requirements:
Any other information that is relevant to your health:

Authorisation form of medical procedures

I, the father ☐ mother ☐ legal guardian ☐ of , residing at hereby authorise École de Savignac, its administration staff, or the Director, to authorise ☐or refuse consent ☐ for medical procedures and surgery on my daughter ☐ son ☐ ward*'s ☐ behalf.

Further, I will not hold École de Savignac, or any of its staff members responsible in any way, and that no right of action shall arise from any loss or damage (including, without limitation, personal injury or property damage) caused by or suffered as a result of the performance/non-performance of medical procedures or surgery on my child/ward.

I have read this form, and by signing this form I understand and agree to what it says. The consent for treatment shall be effective for one year.

Date:
First name, Last name preceded by the words "read and approved"