

**-medical form-**

**Name :**

**First name :**

**Date of birth :**

**Adress :**

**Country :**

**Phone :**

**E-mail :**

**medical information**

allergy :

treatment :

medical problem :

**Family information**

Name and first name of mother :

Name and first name of father :

Phone :

**authorization**

I .....parent (legal guardian) of.....  
....., affirm hereby :

O to have declared the exact information provided on this form

O to allow my child to participate in the activities of the MJC

O to authorizes the Director of the stay to take all necessary measures by the state of the child :  
medical treatment, hospitalization, surgery, ...

Date :

signature :