HEALTH SHEET – ADULT

LAST NAME: _____

FIRST NAME: _____

DATE OF BIRTH: _____

MEN ☐ WOMAN ☐

PASSPORT NUMBER: _____

PHONE NUMBER: _____

BLOOD GROUP: _____

1 – VACCINATION (refer to the health record or vaccination certificates):

MANDATORY	YES	NO	OPTIONAL	YES	NO
Diphtheria			Hepatitis A		
Tetanus			Hépatitis B		
Poliomyelitis			Yellow fever		
Ou DT polio			Typhoid		
Ou Tetracock			Other (specify)		

2 – ADULT MEDICAL INFORMATION :

Are you receiving a medical treatment during your stay? Yes ☐ No ☐

Do you have an emergency protocol? Yes ☐ No ☐

- ALLERGIES :

- Food : Yes ☐ No ☐
- Medication : Yes ☐ No ☐
- Other : _____

- SPECIFY THE CAUSE OF THE ALLERGY AND THE PROTOCOL TO BE FOLLOWED (if self-medication, report it): _____

_____

_____

- OTHER HEALT INFORMATIONS : _____

_____

_____

3 **– PERSON TO NOTIFY IN CASE OF AN EMERGENCY:**

LAST NAME _____ FIRST NAME_____

PHONE NUMBER _____

LINK WITH THE PERSON _____

I, _____ *declare the information given on this form exact.*

Date: Signature: