



Dream Africa

Mia We Zon

HEALTH FORM

Full names :

Date of birth :/...../.....

Gender: M/F

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name : First names:

Address :

Home telephone: Mobile telephone:

Relationship with the participant:

VACCINATIONS

Mandatory vaccinations: Tdap / DT POLIO yes No

MMR: Yes No

Recommended vaccines:

Yellow fever Yes No

Hepatitis A Yes No

Hepatitis B : Yes No

Typhoid: Yes No

Meningitis: Yes No

Varicella : Yes No

Allergies:

Specify the cause of the allergy and what to do

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Asthma: Yes No

Seizure : Yes No

Hospitalization during the last 3 months: Yes No

Indicate below recent health difficulties (chronic illnesses, disability, anxiety, hospitalization, operation, rehabilitation, etc.) specifying the dates and precautions to take.

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Useful recommendations

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Wearing lenses, glasses, hearing aids, etc....

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DOCTOR

Name :

Clinic:

Phone :