MEDICAL FORM

Surname and Name_____

Nationality _____

Address_____

City_____**Zip**_____

Work Phone _____**Cell Phone**_____

E-mail_____

Periodo of Stay – from: _____ **to:** _____

IMPORTANT MEDICAL INFORMATION: _____

_____

ALLERGIES (including those to medication/s):

Allergy to: _____ **Therapy/Prescription:** _____

Allergy to: _____ **Therapy/Prescription:** _____

Allergy to: _____ **Therapy/Prescription:** _____

MEDICAL TREATMENT IN PLACE: _____

_____

Notes: _____

_____

Parent / Guardian Surmane and Name_____

I AUTHORIZE THE USE OF PERSONAL DATA BY THE MEDICAL STAFF, ACCORDING THE ITALIAN PRIVACY LAW.

Date _____ **Signed (parent/guardian)** _____