Medical certificate

*This Medical certificate must be filled out and signed by the parent/legal representative of the participant of the Exupery International Summer School (EISS) 2019.

*This Medical certificate must be additionally signed and sealed by a certified doctor, as a confirmation of an authenticity of the provided information below.

*This Medical certificate is valid only if it is signed by the parent/legal representative of the participant and a certified doctor and should not be older than 3 months, when the participant arrives to the Exupery International Summer School (EISS) 2019.

*This Medical certificate will be reviewed by a nurse of the Exupery International Summer School (EISS) 2019, and will be kept safe in accordance with the law on Personal data protection of the Republic of Latvia in the documentation of the Exupery International Summer School (EISS) 2019.

*Please use this form only.

Name of the participant: _____ _____
(name) (surname)

Date of birth: _____
(Day, month, year)

Citizenship: _____
(Of the participant)

Place of decelerated residence: _____
(Address)

Emergency tel. number: 1) _____ _____
(Telephone number) (Name surname)
2) _____ _____
(Telephone number) (Name surname)

1. Vaccinations (please mark, provide the date)

□ Smallpox _____	□ Typhus _____
□ Diphtheria _____	□ Tetanus _____
□ D.C.G. _____	□ Yellow fever _____
□ Polio _____	□ Cholera _____
□ Encephalitis _____	□ Other _____

*Please provide a copy of the vaccination's passport of the participant

2. Previous history (please mark the correct answer by X, in case of the answer YES, please provide a detailed information)

a) Contagious diseases: □NO □YES

_____

_____

b) Allergic diseases: □NO □YES

_____

_____

c) Metabolic diseases: □NO □YES

_____

_____

d) Cardiovascular diseases: □NO □YES

_____

_____

e) Diseases of nervous system: □NO □YES

_____

_____

f) Diseases of digestive system: □NO □YES

_____

_____

g) Diseases of respiratory track: □NO □YES

_____

_____

h) Hematological diseases: □NO □YES

_____

_____

i) Diseases of muscles, bones: □NO □YES

_____

_____

j) Other diseases: □NO □YES

_____

_____

k) Surgery: □NO □YES

_____

_____

l) Physical exam: □NORMAL □ABNORMAL (please provide a detailed information)

_____

_____

_____

_____

m) Does the participant need any medicals?

□NO □YES (please provide a detailed instruction of use, approved by a certified doctor, including the name of medicals, necessary frequency of use, dosage, etc.)

_____

_____

3. I as parent / legal representative certify that my son / daughter currently is in a good health:

□NO □YES (please provide a detailed information)

_____

_____

SIGNATURES:

Parent / legal representative	Certified doctor
Name, surname: _____	Name, surname: _____ Certificate / license No.: _____ Address of a private practice or a medical institution: _____ Registration No.: _____ Legal address: _____ Mobile phone No. _____ Office / institution phone No. _____ Email: _____
Place, date: _____ _____ _____ _____ (signature)	Place, date: _____ _____ _____ _____ (signature) (seal)