



Formulário Médico / Medical Form - G9 | Itatiaia

Name: \_\_\_\_\_ I.D.(R.G/RNM/DIP): \_\_\_\_\_

Address: \_\_\_\_\_ Tel: \_\_\_\_\_

Father's name: \_\_\_\_\_ Mobile: \_\_\_\_\_

Mother's name: \_\_\_\_\_ Mobile: \_\_\_\_\_

If we cannot contact the parents, another person to contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Residential Phone: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Extension: \_\_\_\_\_

Any Health Issues?

( ) Asthma: \_\_\_\_\_ ( ) Epilepsy: \_\_\_\_\_

( ) Bronchitis: \_\_\_\_\_ ( ) Fainting: \_\_\_\_\_

( ) Sleeping: \_\_\_\_\_ ( ) Allergies \_\_\_\_\_

Medicines taken regularly? Yes ( ) No ( )

Which? \_\_\_\_\_

Medicine taken in case of a fever: \_\_\_\_\_

Blood Group: \_\_\_\_\_ RH factor: \_\_\_\_\_

Vaccines Taken:

( ) Covid vaccine - Type - \_\_\_\_\_ Number of doses - \_\_\_\_\_

( ) Anti tetanus - Month \_\_\_\_\_ / Year \_\_\_\_\_

My child can swim and has permission to swim. Yes ( ) No ( )

In case of an accident:

Name of Medical Insurance provider: \_\_\_\_\_

Type of coverage: \_\_\_\_\_

Policy number (carteirinha): \_\_\_\_\_

Observations: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_