AUTHORIZATION FOR MEDICAL CARE

I, the undersigned :

(First and Last Name of Parent 1)

(First and Last Name of Parent 2)

or (First and Last Name of the Legal Representative)

☐ authorizes ☐ does not allow

the administration of Bordeaux INP to take, in an emergency, all appropriate and necessary measures in the event of an accident or health issues affecting my daughter/son :

NAME:

First name :

Born on :

In :

Social Security Number :

Emergency contact :

Phone :

Done in :

Date :

Signature of Parent 1

Signature of Parent 2

Signature of the legal representative