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|  | **DOSSIER D’INSCRIPTION**  **Accueil d’urgence COVID 19**  **enfants des personnels de santé et des personnels prioritaires** |  |



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| **Etat civil de l’enfant**   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Nom : |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Prénom : |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Date de naissance : |  |  | / |  |  | / |  |  |  |  | Lieu : …………………………. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Adresse : |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Code postal : |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Commune : |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Mail: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | @ |  |  |  |  |  |  |  |  |  |  |  | |

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| **Renseignements administratifs**   |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Numéro CAF |  |  |  |  |  |  |  |  | | | | |  |  | | | | | | |  |  |  |  | | Numéro MSA |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Numéro Sécurité Sociale |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Numéro Police d’Assurance |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  | | | | | | | | | | | | | | | | | | Nom de l’assureur |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   Ecole, Collège, Lycée fréquenté(e) :…………………………………………………… |

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| **Parent(s) de l’enfant ou responsable légal** |
| ***Responsable légal 1***  *Nom : ……………………………………….Prénom :…………………………………….*  *Date de naissance :………………….................lieu :…………………………………..*  *Adresse :……………………………………………………………………………………..*  *Code portal :……………………………………..ville :…………………………………….*  *Tél portable :………………………………………mail :………………………………….*  *Profession :………………………………………………………………………………….* |
| ***Responsable légal 2***  *Nom : ……………………………………….Prénom :…………………………………….*  *Date de naissance :………………….................lieu :…………………………………..*  *Adresse :……………………………………………………………………………………..*  *Code portal :……………………………………..ville :…………………………………….*  *Tél portable :………………………………………mail :………………………………….*  *Profession :………………………………………………………………………………….* |

**Personnes autorisées à venir chercher l’enfant**

Nom-Prénom :………………………………………..Tél :………………………………

Nom-Prénom :………………………………………..Tél :………………………………

**AUTORISATION PARENTALE (obligatoire)**

Je soussigné(e) Madame, Monsieur ……………………………………. autorise ma fille / mon fils \*

…………………………………………… à être accueilli dans le cadre de l’accueil d’urgence COVID 19 à l’ALSH **les Iles / Donnefort** \*.

Mon enfant arrivera à ……h …le matin et repartira à ……h…. en fin d’après-midi le …/03/2020.

**Je m’engage à** :

* avoir souscrit une assurance en Responsabilité Civile auprès de la compagnie de mon choix,
* respecter les horaires journaliers de début **7h30** et de fin d’activités **18h30**,

Fait à ……………………………, le …. /03./ 2020

*\* Rayer la mention inutile*

Signature des représentants légaux,

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|  | **FICHE SANITAIRE DE LIAISON** | **1 - ENFANT**  NOM :  PRÉNOM :  DATE DE NAISSANCE  GARÇON | FILLE |

CETTE FICHE PERMET DE RECUEILLIR DES INFORMATIONS UTILES PENDANT LE SÉJOUR DE L'ENFANT ; ELLE ÉVITE DE VOUS DÉMUNIR DE SON CARNET DE SANTÉ ET VOUS SERA RENDUE À LA FIN DU SÉJOUR.

**2 -VACCINATIONS** (se référer au carnet de santé ou aux certificats de vaccinations de l'enfant).

**ATTENTION : Fournir obligatoirement la photocopie du carnet de santé pour des vaccins obligatoires**

SI L'ENFANT N'A PAS LES VACCINS OBLIGATOIRES JOINDRE UN CERTIFICAT MÉDICAL DE CONTRE-INDICATION  
ATTENTION : LE VACCIN ANTI-TÉTANIQUE NE PRÉSENTE AUCUNE CONTRE-INDICATION

**3 -RENSEIGNEMENTS MÉDICAUX CONCERNANT L'ENFANT**

L'enfant suit-il un **traitement médical** pendant le séjour ?   oui   non  

**Si oui** joindre une **ordonnance** récente et les **médicaments** correspondants ***(boîtes de médicaments dans leur emballage d'origine marquées au nom de l'enfant avec la notice)***

Aucun médicament ne pourra être pris sans ordonnance.

L'ENFANT A-T-IL DEJA EU LES MALADIES SUIVANTES ?

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| RUBÉOLE   |  |  |  |  | | --- | --- | --- | --- | | OUI |  | NON |  | | VARICELLE   |  |  |  |  | | --- | --- | --- | --- | | OUI |  | NON |  | | ANGINE   |  |  |  |  | | --- | --- | --- | --- | | OUI |  | NON |  | | RHUMATISME ARTICULAIRE AIGÜ   |  |  |  |  | | --- | --- | --- | --- | | OUI |  | NON |  | | SCARLATINE   |  |  |  |  | | --- | --- | --- | --- | | OUI |  | NON |  | |
| COQUELUCHE   |  |  |  |  | | --- | --- | --- | --- | | OUI |  | NON |  | | OTITE   |  |  |  |  | | --- | --- | --- | --- | | OUI |  | NON |  | | ROUGEOLE   |  |  |  |  | | --- | --- | --- | --- | | OUI |  | NON |  | | OREILLONS   |  |  |  |  | | --- | --- | --- | --- | | OUI |  | NON |  | |  |

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| **ALLERGIES :** | ASTHME  ALIMENTAIRES |  |

**PRÉCISEZ LA CAUSE DE L'ALLERGIE ET LA CONDUITE À TENIR (si automédication le signaler)**

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LES **DIFFICULTÉS DE SANTÉ** (MALADIE, ACCIDENT, CRISES CONVULSIVES, HOSPITALISATION, OPÉRATION,   
RÉÉDUCATION) EN PRÉCISANT LES DATES ET LES **PRÉCAUTIONS À PRENDRE**.  
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**4 - RECOMMANDATIONS UTILES DES PARENTS**VOTRE ENFANT PORTE-T-IL DES LENTILLES, DES LUNETTES, DES PROTHÈSES AUDITIVES, DES PROTHÈSES DENTAIRES, ETC…PRÉCISEZ.  
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**5 - RESPONSABLE DE L'ENFANT**

NOM ... ...............................................................................................................................................................................................

ADRESSE (PENDANT LE SÉJOUR)............................................................................................................................................................

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TÉL. FIXE (ET PORTABLE), DOMICILE : ……………………………………………….. BUREAU : ………………………….……………….........

NOM ET TÉL. DU MÉDECIN TRAITANT (FACULTATIF) ………………………….……………….........

*Je, soussigné* ………………………….………………………………………………… *responsable légal de l'enfant, déclare exacts les renseignements portés sur cette fiche et autorise le responsable du séjour à prendre, le cas échéant, toutes mesures (traitement médical, hospitalisation, intervention chirurgicale) rendues nécessaires par l'état de l'enfant.*

Date : Signature :