

## MEDICAL INFORMATION FORM

FOR THE STUDENT PREVENTIVE MEDICINE DEPARTMENT  
PLEASE SEND THE DOUBLE-SIDED FORM TO: [centresanteinsa@insa-lyon.fr](mailto:centresanteinsa@insa-lyon.fr)

( STUDENT No.:                     OFFICE USE ONLY )		GENDER : F H	
LAST NAME		FIRST NAME	
DATE OF BIRTH		CITY/TOWN OF BIRTH	

« INSA Lyon, represented by its director, Frédéric Fotiadu, is responsible for processing your personal data in compliance with the General Data Protection Regulation (EU) 2016/679 of 27 April 2016 and the Data Protection Act of 6 January 1978 as amended to provide medical information about you.

For any further information about the processing or your rights, please connect to our website [www.insa-lyon.fr](http://www.insa-lyon.fr) and report to personal data (données personnelles) heading. If you have any queries about your personal data or if you ask for the exercise of your rights, (right to access, to request rectification of your personal data and, in accordance with data protection law, the portability, the restriction or the object of processing, and the erasure of your personal data), please contact our data Protection Officer : [dpo@insa-lyon.fr](mailto:dpo@insa-lyon.fr) ».

For more in depth information on the processing of your personal data, please refer to our website or visit the following link : <https://www.insa-lyon.fr/fr/donnees-eleves>

### TO BE FILLED IN AND SIGNED BY THE PARENTS OR ADULT STUDENT

#### AUTHORISATION FOR EMERGENCY TREATMENT OR HOSPITALISATION

I, the undersigned, Last Name First Name  
Address  
Telephone

acting as an adult student or as the Father, Mother, Guardian(1) of the above-named student,

authorise the Director of the Institut National des Sciences Appliquées de Lyon or representatives thereof to take, on medical opinion – in case of injury or illness of the student throughout his/her schooling – all emergency medical and surgical measures, including possible hospital care.

In case of injury, transportation costs from INSA to the hospital will not be covered by INSA.

Done in on

Signature of the Father, Mother, Guardian or adult student <sup>(1)</sup> and <sup>(2)</sup>

Father's name	Father's profession	Tel.
Mother's name	Mother's profession	Tel.
Number of brothers	Number of sisters	

(1) Cross out if inapplicable

(2) It is in your best interest that this authorisation is requested; however, it does not constitute, on the part of INSA, either ethically or legally, a general guarantee of care and assistance

### TO BE FILLED IN BY A DOCTOR

#### VACCINATIONS (Attach copies)

Tetanus	Latest booster	
Polio	Latest booster	
Hepatitis B	Latest booster	
BCG	Latest tuberculosis test	Result
Measles	Rubella	Mumps
Other vaccinations:		

**TETANUS VACCINE IS MANDATORY TO ATTEND INSA**

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LAST NAME

FIRST NAME

**PERSONAL HISTORY** *(Cross out if inapplicable)*

- Childhood illnesses:      Rubella – Measles – Chickenpox – Mumps – Scarlet Fever
  
- Others:                          Diabetes – Epilepsy – Acute Rheumatic Fever – Kidney Stone – Hepatitis – Heart Disease  
Malaria – Allergies – Nervous Disorder – High Blood Pressure, etc.
  
- Dyslexia                                yes                no  
Date of latest speech assessment (an assessment from within the last 2 years will be requested during the physical)
  
- Any disability(-ies):  
MDPH [Departmental home for people with disabilities] file:      yes                no
  
- Accidents:
  
- Recent surgeries :

## STUDENT'S PHYSICAL

## HEIGHT

**WEIGHT**

**BMI**

**B.P.**

**H.R. (HEART RATE)**

Cardiovascular device:

Breathing equipment:

Digestive device:

Genitourinary equipment:

Locomotion device:

Hearing aid:

Ocular device:

Mental health:

Current treatment:

**SPORTS:** sports are mandatory at INSA

(This is not a certificate, not valid for athletic associations)

The student does not exhibit any contraindications to the practice of sports.

Adaptations needed (cf [Request for sport adjustments](#) to be completed by your doctor)

Explanation:

## Conclusions

Date \_\_\_\_\_

Name, address and telephone number of the attending doctor

**(Stamp and Signature):**