CONSENT FORM

PREVENTIVE MEDICINE "HIPPOCRATES"

The hereby undersigned	parent/legal guardian
of	, student
of	, declare that I consent
and give my permission in order for	my son/ my daughter to be examined
free of charge by doctors that partic	ipate in the program of Preventive
Medicine "Hippocrates" carried out	by "The Smile of the Child".

The program is conducted by "The Smile of the Child" in collaboration with the Managing Authority of the European Territorial Cooperation Programs - Joint Secretariat of the INTERREG V-A Greece-Bulgaria 2014-2020 Cooperation Program, the YMCA of Thessaloniki, the 4th Health District of East Macedonia-Thrace, the Medical Association of Thessaloniki and the Dental Association of Thessaloniki.

The program is carried out with the participation of Pediatricians, dentists and otorhinolaryngologists.

It is important that the child carries the personal health book/ proof of vaccination if it is available.

If there is any important clinical finding I desire to be notified in written.

Date:///
Name:
Phone number:
Signature:





ΤΟ ΧΑΜΟΓΕΛΟ ΤΟΥ ΠΑΙΔΙΟΥ Ζήνωνος Ελεάτου 10 151 23 Μαρούσι Αττικής



