LE GOUVERNEMENT
DU GRAND-DUCHÉ DE LUXEMBOURG
Ministère de la Santé

Direction de la santé

Réservé à la Médecine Scolaire

FORM FOR STOPPING THE APPLICATION OF INDIVIDUALISED SUPPORT PLAN

	Food allergies			Epilepsy			Diabetis
	Allergies			Febrile convulsions			Haemophilia
	Asthma			Cardiac disease			Other (to be specified)
							……………………

Child's surname and first name: ____

National identification number: ____
(or date of birth if no id number)

Name of the school : ____

Day care center : ____

I, the undersigned, ____,

legal representative of____,

hereby request the cessation of the application of the individualised support plan

drafted by Dr ____ .

Date and signature of legal representative : ______________________________