## SCHEDA MEDICA / MEDICAL FORM

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|---|---|---|---|
| Nome:<br>Name: | | | |
| Sesso:<br>Sex: | M | F | |
| Età:<br>Age: | | | Peso:<br>Weight: |
| Gruppo sanguigno:<br>Blood type: | | | |
| Malattie importanti:<br>Important diseases: | | | |
| Terapie farmacologiche:<br>Pharmacological treatment: | | | |
| Interventi chirurgici:<br>Surgical operations: | | | |
| Traumi:<br>Trauma: | | | Allergie:<br>Allergies: |
| Persona da contattare in patria, indirizzo, telefono e cellulare:<br>Contact person in own country, adress, phone and mobile n°: | | | |
| Ospedale scelto per il rimpatrio:<br>Hospital chosen for the repatriation: | | | |

**LA SCHEDA MEDICA DOVRA' ESSERE COMPILATA E RESTITUITA A "TOM42 s.r.l."**
**THIS MEDICAL FORM MUST BE FILLED IN AND RETURNED TO "TOM42 s.r.l."**

Data / Date

FIRMA / SIGNATURE

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