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
	Allergies
	Asthma

	Epilepsy
	Febrile convulsions
	Cardiac disease

	Diabetis
	Haemophilia
	Other (to be specified)
	……

Student's/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, _____,

adult student or legal representative of_____,

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

drafted by Dr _____ .

Date and signature of adult student or legal representative :

Division de la Médecine Scolaire
et de la santé des enfants et adolescents

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