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 participate 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: ……..

ΦΡΟΝΤΙΔΑ.
ΑΞΙΟΠΡΕΠΕΙΑ.
ΙΣΟΤΗΤΑ.

ΕΙΜΑΣΤΕ ΣΕ ΟΛΗ ΤΗΝ ΕΛΛΑΔΑ ΚΑΘΕ ΜΕΡΑ ΟΛΟ ΤΟ 24ΩΡΟ

ΤΟ ΧΑΜΟΓΕΛΟ ΤΟΥ ΠΑΙΔΙΟΥ
Ζήνωνος Ελεάτου 10
151 23 Μαρούσι Αττικής

11040 (αστική χρέωση)
210 38 43 038

info@hamogelo.gr
www.hamogelo.gr