# EURO SPACE CENTER REQUIRED INFORMATION

## GENERAL

NAME ..........................................................................................................................................................

ADDRESS .....................................................................................................................................................

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TELEPHONE/MOBILE...................................................................................................................................

DATE OF BIRTH ............................................................................ MALE / FEMALE ...................................

HEIGHT ..................................................... WEIGHT ................................... BLOOD TYPE .........................

## MEDICAL INFORMATION

DO YOU CURRENTLY SUFFER FROM ANY OF THE BELOW

ASTHMA ............................................. SLEEPING DISORDER ...............................................

EPILEPSY ............................................. SICKNESS .................................................................

SINUSITIS ............................................ CARDIAC MALFORMATION .....................................

BRONCHITIS ........................................ DIZZINESS/VERTIGO ................................................

CONVULSIONS .................................... EAR INFECTION ........................................................

MIGRAINE ........................................... ARTHRITIS ................................................................

OTHER .........................................................................................................................................................

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HAVE YOU SUFFEREED FROM CRANIAL TRAUMATISM? ..............................................................................

HAVE YOU HAD A RECENT OPERATION? IF SO TYPE AND DATE .................................................................

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SPECIAL DIET ..........................................

CLASSICAL .............................................. VEGETARIAN .............................................

NO PORK ................................................ OTHER .......................................................

ALLERGIES TO MEDICINES .........................................................................................................................

OTHER ALLERGIES ......................................................................................................................................

ARE YOU UNDER ANY TREATMENT OR LIKELY TO BE DURING THE COURSE? IF SO WHICH TREATMENT?

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DOCTOR’S NAME AND TELEPHONE NUMBER ............................................................................................

## PRACTICAL DETAILS

**CLOTHING**

IN ORDER TO PARTICIPATE IN THE DIFFERENT ACTIVITIES, SPORTS WEAR AND WHITE PUMPS (OR SHOES WITH NON BLACK SOLES) ARE ADVISED.

DRESSES AND SKIRTS ARE NOT ADVISED.

**LODGING**

BED LINEN IS PROVIDED BUT YOU MAY WISH TO BRING YOUR OWN SLEEPING BAG.

TOWELS AND TOILETIRES ARE NOT PROVIDED.

PLEASE MAKE SURE YOU HAVE A CURRENT EHIC CARD AND TRAVEL INSURANCE WITH YOU.