**FICHA SANITARIA**

NOMBRE:……………………………………………………………………………………………….CURSO:………………………

VACUNAS QUE HA RECIBIDO:

…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………..

ALERGIAS

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ENTIDAD SANITARIA DE REFERENCIA……………………………………………………………………………………….

OBSERVACIONES……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………..

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| NOMBRE, FIRMA Y FECHA |