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|  |  | **Numéro d‘échange - E       /** |  |

|  | Par ordre alphabétique :- **Nom****- Prénom**- **Prénoms** | **M** | **F** | **Date de naissance**(JJ.MM.AAAA) | **Intitulé du diplôme (CAP, BAC PRO, BP,…) suivi de la spécialité** | **Adresse**  | **Nom et adresse du responsable légal** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **1** |            | [ ]  | [ ]  |       |       |       |       |
| **2** |            | [ ]  | [ ]  |       |       |       |       |
| **3** |            | [ ]  | [ ]  |       |       |       |       |
| **4** |            | [ ]  | [ ]  |       |       |       |       |
| **5** |            | [ ]  | [ ]  |       |       |       |       |
| **6** |            | [ ]  | [ ]  |       |       |       |       |
| **7** |            | [ ]  | [ ]  |       |       |       |       |
| **8** |            | [ ]  | [ ]  |       |       |       |       |
| **9** |            | [ ]  | [ ]  |       |       |       |       |
| **10** |            | [ ]  | [ ]  |       |       |       |       |
| **11** |            | [ ]  | [ ]  |       |       |       |       |
| **12** |            | [ ]  | [ ]  |       |       |       |       |
| **13** |            | [ ]  | [ ]  |       |       |       |       |
| **14** |            | [ ]  | [ ]  |       |       |       |       |

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| --- |
| Je confirme que tous les participants ont une assurance maladie. |
|       |       |  |
| Lieu | Date | Signature du chef d‘établissement |