



Work Experience Student Medical Information & Consent Form

Please complete all details in block capitals and RETURN TO SCHOOL by 22nd February 2022

1 STUDENT INFORMATION

SURNAME:		FORM:
FIRST NAME(s):		
ADDRESS:		
DATE OF BIRTH:		
HOME TELEPHONE NUMBER:		
DAYTIME CONTACT NUMBER:		

2 DOCTOR'S INFORMATION

DOCTOR'S NAME:	
ADDRESS:	
TELEPHONE NUMBER:	

3 MEDICAL CONDITIONS

AILMENT:		If YES, please included details of medication / treatment
Hay Fever	Yes / No	
Migraine	Yes / No	
Travel Sickness	Yes / No	
Asthma	Yes / No	
Epilepsy	Yes / No	
Diabetes	Yes / No	
Fainting Attacks	Yes / No	
TETANUS	Yes / No	Has your child been immunised?

ALLERGIES:			
Dust	Yes / No	Nettle Rash	Yes / No
Plasters	Yes / No	Insect Stings	Yes / No
Penicillin	Yes / No	Food Allergies	Yes / No

			Yes / No
PLEASE INDICATE DETAILS OF ANY OTHER ALLERGIES			

Does your child require/carry an EPI PEN?	Yes / No
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Is there any other Medical Information which you feel the School / Employer should know about?	I will disclose personal information directly with the employer e.g. any medical conditions, criminal activities etc.
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I declare that my child is fit to undertake work experience activities as detailed in the School's letter.

I have declared any Medical concerns on this form.

I consent to the staff in charge giving written permission for any hospital treatment, including transfusion or operation, if a delay in requesting my consent would hinder my child's treatment.

Signed by Parent / Carer Date