ST BERNARD'S HIGH SCHOOL

WORK EXPERIENCE MEDICAL AND CONSENT FORM

Please complete **ALL** sections and return to **Mrs Davies** by **Friday 11th February 2022**

STUDENT INFORMATION:

SURNAME:		FIRST NAMES:
FORM	ADDRESS:	
DATE OF BIRTH:	TEL: (Home)	DAYTIME:
DOCTOR'S NAME:		CONTACT PERSON [Mother: Father: Carer: other Relative
TELEPHONE No:		NAME:
		TELEPHONE NO:

Does your daughter/son suffer from any of the following (please delete as appropriate); If YES, please indicate any medication that is usually prescribed.

Condition		IF YES, details of medication / treatment and any relevant information
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	Has your daughter been immunised? YES / NO Year	
Allergies	YES/NO	[Please indicate]
Other conditions		

a) I have read the information and I agree to my daughter/son taking part in the Work Experience. I declare her/him fit enough to undertake these activities. I have declared any medical concerns on this form and agree to this information being shared with the employer.

b) 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 daughter's/son's progress.

c) Students will be required to make their way to and from their Work Placement.

Signed by Parent / Guardian: Date: