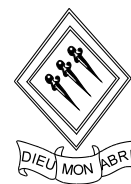


ST BERNARD'S HIGH SCHOOL

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		

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

Signed by Parent / Guardian:

Date: