**ST BERNARD’S HIGH SCHOOL**

**WORK EXPERIENCE MEDICAL AND CONSENT FORM (YEAR 12)**

Please complete **ALL** sections and return to Mrs L Phillips ([lph@stbernards.southend.sch.uk)](mailto:lph@stbernards.southend.sch.uk) by Monday 22nd April 2024.

**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 |  |  |
|  |  |  |
|  |  |  |

1. I have read the information and I agree to my daughter/son taking part in 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.
2. 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.
3. Students will be required to make their way to and from their Work Placement.

Signed by Parent/Guardian:                                                                   Date: