**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) 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: