SHOEBURYNESS HIGH SCHOOL

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WORK EXPERIENCE 9-20 JULY 2018

MEDICAL AND CONSENT FORM

Please complete **ALL** sections and return to school as soon as possible

THIS FORM WILL BE FORWARDED TO THE EMPLOYER

PUPIL INFORMATION:

Surname: ……………………………….. **First Name(s):** ……………………………………………………… **Date of Birth:** ……………………

Address: ………

MAIN CONTACT DETAILS	ALTERNATIVE CONTACT DETAILS
Name: ………………………………………………………………………	**Name:** ………………………………………………………………………
Telephone: …………………………………………………………………	**Telephone:** …………………………………………………………………
Alternative Telephone: ……………………………………………………	**Alternative Telephone:** ……………………………………………………

Does your child suffer from any of the following (please delete as appropriate)?

AILMENTS

		IF YES please give 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	
Any Others	Yes/No	

Continue on a separate sheet if necessary

ALLERGIES

Dust	Yes/No	Penicillin	Yes/No
Nettle Rash	Yes/No	Food Allergies	Yes/No
Elastoplast	Yes/No		
Insect Stings	Yes/No		

Any other allergies (please give details): ……

TETANUS Has your child been immunised: Yes/No **YEAR**: ………………………………………………………………

Doctor's name: ……………………………………………………………………… **Telephone Number:** …………………………………………………

I agree to authorise members of staff during the course of the work experience placement to approve such medical treatment for my child as is deemed necessary in an emergency on the advice of a qualified medical practitioner. I set out above (and continued on a separate sheet if necessary) any medical condition from which my child is suffering, together with details of the treatment required.

Signed by Parent/Guardian ………………………………………………………………… **Date:** ………………………………