**FORM C**

**Medical Questionnaire Form for WoRK Experience**

**This form should be completed by a Parent/Carer and Employer. Employer should retain this form for the duration of the placement.**



|  |  |  |
| --- | --- | --- |
| Work Experience at: |  |  |
| Dates: **Monday 10th July – Friday 14th July 2023** |  |  |
| Student Name: |  | Form: |
| Parent/Carer’s Name: |  |  |
| Home Address: |  |  |
| Home telephone: | Mobile number: |  |

* I wish my child: ………………………………………………………………………to be allowed to take part in work experience with the employer/company named above.
* I have ensured that my child understands that it is important for their safety that any rules and instructions given by the staff in charge are obeyed.
* I understand that unless members of staff at the placement are negligent, they cannot be held responsible for any loss, damage or injury suffered by my child.

**I consent to any emergency medical treatment necessary during the work experience, including anaesthesia and blood transfusions**

|  |  |
| --- | --- |
| Signed: | Parent/Carer |
| Name, address and telephone number of family Doctor: |  |
|  |  |

**EMERGENCY CONTACT NUMBERS:**

Please indicate below telephone numbers with appropriate times at which a parent/carer can be contacted in case of emergency **during** the work experience. Continue on a separate sheet if necessary.

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Parent/Carer or alternative contact | Relationship to pupil | Telephone Number (with area code) | Please state dates and times contactable on each number |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

# **Student Medical and Other Information for THE Work Experience EMPLOYER**

|  |  |
| --- | --- |
| **Student’s full name:** | **Form:** |

|  |
| --- |
| **Administering medicine** |
| By ticking the boxes below and signing this sheet you are giving consent for the below to be administered during the working day between 12pm-2pm and confirming that you have administered these medications in the past **without** adverse effect. |

|  |  |  |
| --- | --- | --- |
| **MEDICATION** | **CONSENT GIVEN** | |
| **YES** | **NO** |
| ANTI-HISTAMINE |  |  |
| IBUPROFEN |  |  |
| PARACETAMOL |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Has your child any of the following medical conditions or allergies: (Tick box as appropriate)** | | | | | | |
| Asthma |  |  | Allergy to Artificial colouring | | |  |
| Heart Condition |  | Egg Allergy | | |  |
| Absence seizures/Epilepsy |  | Allergy to dairy produce/lactose intolerant | | |  |
| Fainting |  | Allergy to nuts of any type/quantity | | |  |
| Headaches |  | Seafood Allergy | | |  |
| Migraines |  | **Any other known allergies – please specify below** | | | |
| Diabetes |  |  | | | |
| Panic Attacks/Hyperventilation |  |  | | | |
| Medicated period pains |  | **Allergy to any medication – please specify below** | | | |
| Travel Sickness |  |  | | | |
| Hypermobility |  |  | | | |
| Severs disease |  | **Is your child exempt from wearing a face covering?** | Yes | No | |
| **If you have ticked any of the above, if your child has any other medical conditions, illnesses, disabilities or advice to follow in an emergency, please give details below (continue on a separate sheet if necessary)** | | | | | | |
|  | | | | | | |
| **If your child has a healthcare plan, it is parent/carers responsibility to share this with the employer.** | | | | | | |
| **If your daughter is on the SEND (Special Educational Needs and Disabilities) register, please complete the box below with any relevant information for her employer (continue on a separate sheet if necessary)** | | | | | | |
|  | | | | | | |

**Please check that you have not left out any information that staff caring for your daughter should know, no matter how trivial it may seem.**

Parent/Carer **SIGNED**: ………………………… **PRINT NAME**……………………*……***DATE**: …………

Employer **SIGNED:……………………………… PRINT NAME………………………….DATE…………..**