**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: **8th – 12th July 2024** |  |  |
| 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…………..**