

**WORK EXPERIENCE 2024**  
**MEDICAL DETAILS AND PLACEMENT CONSENT FORM**

To help us make sure that students Work Experience placements are suitable, please provide us with the following information.

**Student's name-**

| Does your son/daughter have any of the following?             | Yes                      | No                       |
|---|--------------------------|--------------------------|
| allergies/skin conditions - if yes, please give details below | <input type="checkbox"/> | <input type="checkbox"/> |
| conditions affecting mobility or the use of arms or legs      | <input type="checkbox"/> | <input type="checkbox"/> |
| asthma  | <input type="checkbox"/> | <input type="checkbox"/> |
| diabetes  | <input type="checkbox"/> | <input type="checkbox"/> |
| epilepsy  | <input type="checkbox"/> | <input type="checkbox"/> |
| impaired colour vision  | <input type="checkbox"/> | <input type="checkbox"/> |
| impaired eyesight (if not rectified by use of glasses)        | <input type="checkbox"/> | <input type="checkbox"/> |
| impaired hearing  | <input type="checkbox"/> | <input type="checkbox"/> |

**IMPORTANT:** Additional information from parents: (including any other medical condition, medication, additional needs – continue on separate page if required)

I consent to my son/daughter: \_\_\_\_\_ taking part in the Work Experience Programme and confirm that I have read all the information about Work Experience and I agree that he/she should observe the conditions set out by the school and will encourage him/her to do so. I also agree that data will be shared with the Work Experience placement as outlined in the 'Information for Parents' letter.

Signed \_\_\_\_\_ (Parent/Carer)

Signed \_\_\_\_\_ (Student)

Date \_\_\_\_\_

Please return this form to Mrs Newton in the school library ASAP.

[b.newton@bishopchalloner.bham.sch.uk](mailto:b.newton@bishopchalloner.bham.sch.uk)