WORK EXPERIENCE 2026
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	☐	☐
conditions affecting mobility or the use of arms or legs	☐	☐
asthma	☐	☐
diabetes	☐	☐
epilepsy	☐	☐
impaired colour vision	☐	☐
impaired eyesight (if not rectified by use of glasses)	☐	☐
impaired hearing	☐	☐

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 Miss Jacques in Student Services ASAP.
a.jacques@bishopchalloner.bham.sch.uk