

Bishop Rawstone C of E Academy Work Experience Self-Placement Form

****Student/parent - School will not accept this form without a copy of the relevant insurance(s)**
The deadline for submission is Monday 10 June 2024**

Employer Name & Placement Address

Student Name & Address

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Postcode

Date of Birth:

Name of Contact:

School:

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Bishop Rawstone C of E Academy

Employer Telephone No:

Dates of Work Experience:

Monday 8 July – Wednesday 10 July 2024

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Mobile No:

I confirm receipt of the student's medical form

Work Experience Job Title

Brief Description of Duties

I confirm that:

- We will take all possible care of the student's health and safety, recognising her inexperience, immaturity and lack of awareness of risks.
- We will ensure that the student performs meaningful work as previously agreed in the job description.
- We will not discriminate on the grounds of gender, race, disability, religion, age or sexual orientation.
- We will inform the school immediately, should we for any reason have to send the student home.
- We understand it may be necessary for a representative of the school to undertake a visit prior to the student taking up the placement.
- We have Employers & Public Liability Insurance and will inform our insurance company that we have accepted the above-named student for Work Experience. (See attached copy of my employer's liability insurance)

**** PLEASE ATTACH A COPY OF YOUR EMPLOYER'S LIABILITY INSURANCE CERTIFICATE TO THIS FORM – SHOULD THE STUDENT BE TRAVELLING IN A MOTOR VEHICLE PLEASE CAN YOU ALSO ATTACH A COPY OF THE RELEVANT MOTOR VEHICLE INSURANCE CERTIFICATE**** Please note that the student cannot join you without this information

Signed: **Date:** **Position in Company:**

Medical Questionnaire for Year 10 Work Experience – This is to be handed to the employer

The following information is required by the employer in order to provide a safe and healthy placement.

Failure to disclose accurate information could put your son/daughter at risk and will result in the placement being withdrawn

To be completed by the parent or guardian of:

Student's Name:

Form/Tutor:

Does he/she:	YES OR NO	IF YES PLEASE DETAIL
1. have any restrictions of normal physical activity?		
2. need support during the period of the work placement?		
3. have skin allergies or eczema? (or any other allergies, e.g. to nuts?)		
4. have bronchitis, asthma or chest complaints?		
5. have a hearing disability or discharging ears?		
6. have heart disease/any other related which would affect their capacity to carry out physical tasks?		
7. have diabetes?		
8. experience fits or fainting attacks?		
9. have a significant colour vision defect or other visual disability?		
10. have a learning disability which might affect their ability to understand or act on instructions?		
11. have <i>any other</i> health problems (including the need for regular medication?) * <i>Attach a separate sheet of paper if necessary</i>		

Signed: Parent/Guardian

Date: