



MEDICAL INFORMATION SHEET

Work Experience Placement at	
Date:	25 th – 29 th June 2018

Name	
Tutor Group	
Date of Birth	
Home telephone no (with STD code)	
Emergency contact 1 (name & number)	
Emergency contact 2 (name & number)	

Name of Doctor	
Address of Doctor's Surgery	
Phone number of Doctor's Surgery	
Date of last Tetanus injection *	

* The school nurse strongly advises all students to have a tetanus booster before work experience

Any allergies	
Any significant medical/personal information	
Details of any regular medication	
Special dietary requirements	

DECLARATION

1. I agree that my child may participate in work experience.
2. I agree that my child is fit to participate in work experience.
3. I give permission for any emergency medical treatment which may be necessary whilst my child is away from home.
4. I give permission for my child to travel in a vehicle provided seat belts and insurance are in place.
5. I understand that this information may be shared with the employer.

Signature (Parent/Carer)	Name (please print clearly)	Date

PLEASE COMPLETE AND RETURN TO MRS STANDERWICK