

## Work Experience Student Health Declaration Form

Student Name:

Date of Birth:

Year Group:

Work Experience Business Name:

Work Experience Business  
Address:

Please confirm if the student has any of the following health conditions:

Physical Disabilities

Allergies?

Asthma or Chest Complaints?

Skin Conditions?

Hearing or Visual Impairments?

Heart Conditions which affects their ability to carry out physical tasks?

Diabetes

Epilepsy

Does the student take any medication on a regular basis?

If you have answered **Yes** to any of the questions, or **any other issues** which should be considered (including emotional or behavioural) please provide further details here:

### Parental Agreement and Acknowledgement

I agree that the information given above for the work experience employer.

can be shared appropriately with

Signed

Date

Name

### Work Experience Employer

I have read and acknowledge the health and medical information above and can confirm that we will take all relevant information into account during the placement

Signed

Date

Name