WORK EXPERIENCE

MEDICAL HEALTH CHECK FORM

For completion by Parent/Carer

NAME OF PUPIL: ……

Please complete the following questions by ticking the appropriate box and hand the form to the **PLACEMENT PROVIDER**.

Does your child suffer from any of the following:- *(Please give more details below)*	**YES**	**NO**
Restrictions of normal physical activity or games		
Skin allergies or eczema (or any other allergies e.g. to nuts)		
Bronchitis, asthma or chest complaints		
Hearing disability or discharging ears		
Heart problems or disease affecting their capacity for physical tasks		
Diabetes		
Experience fits or fainting attacks		
Significant colour vision defect or other visual disability		
Learning disability which might affect their ability to understand or act on instructions		
Health problem (including the need for regular medication)		

Other relevant information: _____

_____

_____

_____

_____

PLEASE GIVE THIS FORM TO THE PLACEMENT PROVIDER