



APPLICATION FOR CHILD EMPLOYMENT LICENCE

PART A: Child's Details (To be completed by Parent / Guardian)

Name of child	<input type="text"/>	Date of birth	<input type="text"/>
Address	<input type="text"/>	Telephone	<input type="text"/>
School	<input type="text"/>		

PART B: Employment Details

Name of Employer ?	<input type="text"/>	Tel No ?	<input type="text"/>
E-Mail Address:	<input type="text"/>	Fax Number	<input type="text"/>
Address ?	<input type="text"/>		
Occupation in which Employed ?	<input type="text"/>		
Place in which Employed ?	<input type="text"/>		
Days of week Employed ?	<input type="text"/>		
Times at which Employment <i>Begins and Ends:</i>			
(a) Schooldays	<input type="text"/>		
(b) Saturdays & Holidays	<input type="text"/>		
(c) Sundays	<input type="text"/>		

PART C: Parent / Guardian Endorsement

I certify that the information given is correct and that the employer has explained about and carried out a risk assessment prior to commencement of employment.

Signed _____ Date _____

PART D: Employers Endorsement

I the undersigned do certify that a risk assessment has been carried out, in relation to the above employment, and that the Parents/Guardians have been notified and understand the findings.

Signed _____ Date _____

Please Delete as appropriate: Mr/Mrs/Ms/Miss

Print Name in Full: _____ Job Title: _____

Please ensure that all sections of the Application Form and Medical Questionnaire are completed fully and returned to: - Education Welfare Service, Wigan Investment Centre, Waterside Drive, Wigan WN3 5BA

WIGAN METROPOLITAN BOROUGH COUNCIL
EDUCATION COMMITTEE
EDUCATION WELFARE SERVICE



Medical Questionnaire

Name of child Date of birth

Address Telephone

School

Family Doctor

Address

Please answer the following questions
failure to do so may result in an unnecessary medical examination

1. Does your child have any of the following ?

Asthma or chest trouble	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Heart Trouble	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Skin Problems	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Diabetes	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Fits or Epilepsy	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Physical disability	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

2. Does your child take any regular medication ? Yes No

3. Does your child have hearing problems? Yes No

4. Does your child have poor vision? Yes No

5. Is your child attending a hospital specialist? Yes No

If Yes, please give details in the space provided below.

6. Is there anything else you would like the doctor to know Yes No

Please give details

7. I consider my child fit to undertake this work Yes No

Parent / Guardian Endorsement

Signed _____ Date _____

Certificate of Medical Examination (for office use only) Medical Assessment Yes No

This is to CERTIFY that the pupil referred to above has been medically assessed and is * fit / unfit to undertake the proposed employment.

* Please delete as appropriate

Remarks _____

Print Name _____ **Base** _____

Signed _____ **Date** _____
(Community Child Health Doctor)