

# John Willmott School

## Sixth Form Admission Booklet

Student Name:

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High Standards

High Expectations

Huge Aspirations

**John Willmott School**

Reddicap Heath Road, Sutton Coldfield B75 7DY

Telephone: 0121 378 1946

School Email: [enquiry@jws.bham.sch.uk](mailto:enquiry@jws.bham.sch.uk)

Website: [www.johnwillmottschool.co.uk](http://www.johnwillmottschool.co.uk)

Headteacher: Mrs T Peters

Head of Sixth Form: Ms T Richards

**PERSONAL INFORMATION FORM**

Legal Surname \_\_\_\_\_

Legal First Names \_\_\_\_\_

**(Please provide a copy of birth certificate)**

Middle Name \_\_\_\_\_

Name known by \_\_\_\_\_

Sex Male  Female

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Postcode \_\_\_\_\_

Parental Contact Numbers: Home Tel \_\_\_\_\_ Mobile Tel \_\_\_\_\_

Parental Email Address \_\_\_\_\_

Student Contact Numbers: Home Tel \_\_\_\_\_ Mobile Tel \_\_\_\_\_

Student Email Address \_\_\_\_\_

Present School \_\_\_\_\_ Form \_\_\_\_\_

Please list 4 subject you wish to study in preference order

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

**CONTACT 1**

Details of those people who should be contacted in case of an emergency in priority order. Please include any separated parent contact details if required.

Mr / Mrs / Miss / Ms

Surname

First Name

Relationship to student

Address (if different from student)

Home Telephone number

Mobile Telephone number

Contact Email

Does this contact have parental responsibility?

Yes No **CONTACT 2**

Mr / Mrs / Miss / Ms

Surname

First Name

Relationship to student

Address (if different from student)

Home Telephone number

Mobile Telephone number

Contact Email

Does this contact have parental responsibility?

Yes No **CONTACT 3**

Mr / Mrs / Miss / Ms

Surname

First Name

Relationship to student

Address (if different from student)

Home Telephone number

Mobile Telephone number

Contact Email

Does this contact have parental responsibility?

Yes No

## MEDICAL INFORMATION QUESTIONNAIRE

Have you been diagnosed by a doctor with any of the following medical conditions. Please give as much detail including medication, such as Epi-pen, Insulin and inhalers. If you need more space to include details please send the information on a separate sheet. Any information provided will be treated in the strictest of confidence.

Heart trouble	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Raised blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bronchitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Lung condition(s)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Stomach problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Digestive problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Abdominal problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Blood disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>
History of epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Fainting attacks	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Migraines	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hearing loss	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Visual Impairments	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bladder problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Urinary problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>			

Allergy to Foods (i.e. nuts/dairy produce etc.) Yes  No

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Other allergies (i.e. hayfever/medicine etc.) Yes  No

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Do you have an existing medical care or allergy management plan in place?\* Yes  No

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\*Please provide a copy

Are there any other medical conditions not listed you would like us to be aware of?\* Yes  No

Do you have any learning or physical disability that affects your day to day life?\* Yes  No

GP Surgery

Phone Number

Address

If you require medication to be administered during school hours we are happy to hold any medication in school such as Epi-pens, insulin and inhalers by prior arrangement. The school is not permitted to administer any medication (including inhalers) without the required consent form.

These medicines MUST be prescribed by a doctor, in date, in the original container with dosage instructions and dispensing label. Parents/Carers will need to complete and sign a Medication Administration form available on request from the School Office.

Schools hold information on students in order to run the education system. Information will be used to administer your progress through the education system and may be shared with the DFE, other schools and educational establishments to which you may progress, future and prospective employers, health and welfare practitioners and Youth Services. Youth Services are entitled by law to receive details of students' and parents' names and addresses, but often find additional information beneficial when dealing with students. If you do not wish additional data to be disclosed to Youth Services, then please ask your Parent/Carer to write to the Headteacher, otherwise we will assume we have consent to disclose additional relevant information.



