DE LA SALLE HOLY CROSS COLLEGE

Catholic Education

INDEMNITY AND MEDICAL EMERGENCY INFORMATION

I, _____ the parent/guardian/custodian of _____
(Full name and surname) *(Full name and surname of pupil)*

with ID number_____, do hereby give permission for the aforementioned pupil to participate in all
(Pupil ID Number)

school activities, tours and excursions.

I hereby fully indemnify DE LA SALLE HOLY CROSS COLLEGE, its staff, members of the Board of Governors of the College , College employees, agents and representatives, against any claim/s with regards to any loss of property or loss of any goods, or any injury, bodily harm, death or other form of harm caused to the aforesaid pupil (hereinafter referred to as "the pupil") or to items or goods in the possession or control of the pupil, however arising, unless gross negligence can be proven against the College.

In the event of any medical treatment of any nature being required in respect of the pupil, I hereby grant to all teachers, staff and responsible persons in control, so mandated by the College, full power to authorize any such treatment which he/she may deem fit. I hereby accept full responsibility for payment of all medical costs so incurred and all other costs incidental thereto. The authorization by the College representative in terms of this clause will only apply, in the event of an emergency and when the parent/guardian/ custodian cannot be reached telephonically to attend directly to the medical instruction required to be given, relating to the medical treatment necessary for the pupil. This makes it essential that you, the signatory hereto, to ensure that your current telephone numbers in use, are always communicated to the school, to keep the school records updated at all times. Please also immediately advise us of any changes to your contact telephone number/s so that you can be contacted when medical treatment may be required to be given to the pupil.

I agree to the College making use of images and video of the aforementioned child, at its sole discretion. When exercising this discretion, the College will seek to avoid impinging on the child's modesty or presenting the child in a negative light. When the College chooses to use images for marketing purposes, or allows external agencies to do so (as opposed to using pictures in newsletter and the school magazine or other similar media, or in the course of filming ordinary school activities), reasonable steps will be taken to secure my permission prior to the images being used in this way.

I, the parent/guardian/custodian, by my signature hereto also acknowledge that I am the party entitled to provide this information and issue this indemnity in respect of the pupil. Should it transpire that I am not the responsible person to issue this mandate and indemnity, I by my signature hereto shall hold myself liable to the College for the financial consequences flowing from the granting of this indemnity and instruction by me, on my part, howsoever arising.

I hereby declare that the pupil suffers from the following pre-condition and/or cannot use certain types of medication:

- ☐ None
- ☐ Mild condition or intolerance
- ☐ Life threatening condition or allergy
- ☐ Other – Specify _____

In the case of life threatening conditions, I understand that it is compulsory for the child to wear a medical bracelet / necklace at all times. I hereby declare that the information provided overleaf shall be updated by myself as the need arises. If the medical aid details or pupil's medical condition changes subsequent to this information being supplied by me to the College, I will notify the College of the updated information, in writing.

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Signed at _____ this _____ day of _____ 20_____

Full Name: _____ Relationship to Pupil: _____

ID Number: _____ Signature: _____

Postal Address: P O Box 35687, Northcliff, 2115
Contact Details: Telephone: 011 782 5217 / 4896 **Fax:** 011 782 8489 **Web**: www.delasalleholycrosscollege.co.za
PBO No: 18/11/13/3577

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MEDICAL INFORMATION

NAME: _____ **CLASS AND GRADE:** _____

CONTACT DETAILS:

	Mother	Father	Other
Cell:	_____	_____	_____
Work:	_____	_____	_____
Home:	_____	_____	_____
Email:	_____	_____	_____

MEDICAL AID DETAILS:

Medical aid name: _____

Medical aid number: _____

Medical aid plan: _____

Main member name: _____

Main Member ID: _____

PHYSICAL ADDRESS OF MAIN MEMBER

_____

_____

Suburb: _____

Postal Code: _____

MEDICAL PRACTITIONER DETAILS:

Doctor's Name: _____

Telephone number: _____

MILD CONDITIONS

Allergy / Illness / Condition: _____

Medication: _____

Dosage: _____

Where is medication kept?: _____

SERIOUS / LIFE THREATENING CONDITION

If child suffers from a life threatening condition/illness/allergy, a medical bracelet/necklace is compulsory.

Allergy / Illness / Condition: _____

Medication: _____

Dosage: _____

Where is medication kept?: _____

Should medical intervention be required, the school will contact an ambulance on 083911. Milpark Hospital is our hospital of choice.

_____	_____	_____
Parent Name	**Parent Signature**	**Date**