AGAPE CHRISTIAN SCHOOL

INDEMNITY FORM

50 CORNELIUS STREET
WELTEVREDEN PARK EXT 66
ROODEPOORT 1708
TEL: (011) 475-1661 / (011) 675-6540
FAX: (011) 475-9470

I/We …….. Parent(s) / Legal guardian of

…… (full name of pupil).

Residential Address: …… ……..

hereby give consent for my child to take part in all of the camp and extramural activities of the school including but not exclusively: *games, athletics, soccer, cricket, netball, tennis, swimming, choir, drama, educational tours, leadership courses, excursions and visits to places of interest. Specific excursion:* _____

I fully understand and accept that all activities, tours and excursions shall be undertaken at my child's risk. I undertake on behalf of myself, my executors, my spouse and my child to indemnify the school, the Principals and Staff against and from any and all claims whatsoever that may arise in connection with any loss or damage to property, or injury to the person of my child. I accept that all reasonable precautions will be taken to ensure the safety and welfare of my child and that I shall be held responsible for the payment of medical and / or hospital accounts, where applicable, should any injury be sustained.

I cede my powers as parent / guardian to the principal of the school or his / her representative should medical treatment / surgery be deemed necessary for my child. In the event of an emergency and I / we am / are unable to be contacted, I authorize the school to have my child treated at my expense by a doctor nominated by the school. As far as I know he / she is in good health. However, the persons responsible should please note the following: (Please state aspects that the teaching staff should be aware of e.g. allergies, tendency towards abnormal bleeding, epilepsy, etc.)

……..

……..

SIGNATURE OF PARENT: _____ DATE: _____

The following information is essential in case of medical treatment or hospitalization:

Name and address of employer: _____

Name of Medical Aid Fund: _____ Medical Aid Number: _____

Member's name: _____ Force No. (Police, etc.)_____

Complete this section only if you are of the opinion that you qualify for a reduced medical tariff:

Occupation: _____ Number of dependants: _____

Gross annual income: husband: _____ wife: _____

_____	_____	_____
SIGNATURE OF PARENT / GUARDIAN	DATE	ID NUMBER – PARENT