



INDEMNITY FORM

1. I, _____ (full name and surname) the parent / guardian
of _____ (full name, surname and I.D. no. of learner) hereby give permission for him / her to participate in any school activity or outing.
2. I acknowledge that all reasonable precautions will be taken to protect the safety and welfare of my child, and I hereby agree that my child attends Southern Cross Schools and participates in any activities organised or supervised by the school, whether curricular or extra-curricular, entirely at his / her own risk and that neither the school nor any of its employees shall incur any liability of whatsoever nature for any injuries, howsoever arising, suffered by my child irrespective of the nature, extent or cause thereof.
3. I understand that Southern Cross Schools is within a nature reserve and as such there are potentially dangers related to contact with a wide variety of wild creatures. I acknowledge that all reasonable precautions will be taken to protect the safety and welfare of my child and to educate my child in terms of the most appropriate behaviour to minimize the possible dangers. I hereby agree that my child attends Southern Cross Schools entirely at his / her own risk despite the potential dangers that exist from contact with wild animals. I undertake not to hold the school nor any of its employees liable for any injuries, howsoever arising, suffered by my child irrespective of the nature, extent or cause thereof.
4. I agree that I shall remain liable for the payment of medical expenses, including hospitalisation costs, should medical treatment be necessitated as a result of injury sustained by my child.
5. I expressly authorise the Head of Southern Cross Schools or his duly authorised representative to act on my behalf, as my agent should emergency medical treatment, including surgery, be deemed necessary for my child.
6. I warrant that as far as I know my child is in good health. However, my child suffers from, or is prone to, the following (e.g. allergies, tendency towards abnormal bleeding, epilepsy etc.):

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

Name and address of employer: _____

Name of medical fund: _____

Complete only if you are of the opinion that you qualify for a reduced medical tariff (hospital treatment):

(i) Occupation: _____

(ii) Gross annual income, Husband: _____ Wife: _____

(iii) Number of dependants (excluding spouse):

Age of dependants (excluding spouse): _____