First Friends Preschool
Cell: 060 679 3548
Lilford Road, Hout Bay
e-mail: Firstfriendspreschoolhb@gmail.com

MEDICAL EMERGENCY FORM

We request you to sign this form to make it possible for your child to receive medical attention should a medical emergency arise.

I_____parent/guardian of_____,

hereby willingly agree for my child to be treated by a doctor in the event of a medical emergencywhen, at the discretion of the School Principal and/or person so designated, immediate medical attention is required.

The following medical information must be given to the practitioner treating my child during such an emergency:

_____

_____

ALLERGIES:_____

I understand that I will be personally accountable for the costs incurred for such treatment and wish to inform the school that I am/am not a member of a Medical Aid Fund.

Medical Aid Fund Name:_____Membership #: _____

PLEASE INCLUDE A COPY OF YOUR MEDICAL AID CARD AND THE MAIN MEMBERS ID

No Medications will be administered at school. Except:

a) If a child needs to complete a course of antibiotics and is well enough to attend school
b) If a child is on chronic medication – Will need written consent and detailed instructions in how to administer medication in the event of an emergency.

I, furthermore, indemnify the school from any claim that may arise from either an injury sustained onthe school premises or pursuant to the referral to a medical practitioner.

Signed at _____ on this _____ day of _____ 20____

Sign: _____Relationship to child: _____