Important Information & Permissions for Emergencies and Collection of Child:

No.	Details	Complete	
1	**Name of child**		
2	**Surname**		
3	**Medical Aid**		
4	**Medical aid number**		
5	**Main member**		
6	**Telephone number of parents**		
7	**Allergies**		
8	**Chronic conditions & medication**		
9	**Has your child had a tetanus inoculation**		**Date:**

NB: A copy of medical aid card included Y/N.

I _____ (parent/guardian's name) being the parent/legal guardian of _____ (child's name) hereby give consent that my child may be transported in the case of an emergency by a Curious Minds Stimulation Centre cc. (1016 Justice Mohamed Street, Brooklyn, Pretoria) staff member from Curious Minds Stimulation Centre or *vice versa*, in a motor vehicle or alternative mode of transportation to the nearest hospital . In the event that an ambulance is needed, Curious Minds Stimulation Centre will contact an ambulance on 082 911. All expenses incurred will be for your account.

First Contact Person in case of emergency:

Name and surname:	
Phone number/cell number:	
Physical address:	

Second Contact Person in case of emergency:

Name and surname:	
Phone number/cell number:	
Physical address:	

Collection Password

Please provide us with your unique collection password:

The following person(s) have my permission to pick my child up from school.

1. Name:_____ Phone:_____

Relationship to child:_____

2. Name:_____ Phone:_____

Relationship to child:_____

3. Name:_____ Phone:_____

Relationship to child: _____

Media

Do you give us permission to:

	Yes	No	Initial
Share your contact details with other parents			
Publish pictures of your child on any marketing (Adverts, leaflets, etc.)			
Publish pictures of your child on our closed Curious Minds Facebook group or website			

PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

I, _____ (full name and surname), and ID number:_____, being the parent/guardian of learner (full names) _____, date of birth _____, Grade/Class_____ hereby give permission for him/her to have the following medication administered while at school.

Please initial in the table below which medication (or generic equivalent thereof) you give the designated staff permission to administer, at their discretion where deemed necessary. In the event of medication being administered and no desired effect having been reached within two hours, you will be contacted to collect your child. All reasonable attempts will be made to contact parents/guardian on telephone numbers supplied in the indemnity form. NO medication will be given if you have not initialled in the "yes" block on this form, or if this form is not signed.

Medication	Indication	Yes	No
Allergex/Prohist	Antihistamine		
Antihisan	Antihistamine		
Prospan	Mucolytic		
Bactroban or similar	Antibacterial		
Buscupan/Hypersol	Antispasmodic		
Panado syrup	Analgesic ad antipyretic		
Neurofen	Analgesic ad antipyretic		
Wecsin powder	Powder used for grazes		
Brolene/Allergex	Eye drops		
Rescue remedy	Emotional stress		

Please note that all personal medication required for asthma, allergies, bee stings, etc. MUST please be sent to the school clearly marked in a sealed zip lock bag with dosage/instructions as well as emergency contact details clearly marked.

_____

Parent/Guardian Signature

_____

Witness

_____

Date