

Is student new to WCA? Yes \_\_\_ No \_\_\_

Has any information changed since enrollment? Yes \_\_\_ No \_\_\_

**WARNER CHRISTIAN ACADEMY  
MEDICAL AUTHORIZATION**

**I. STUDENT INFORMATION**

STUDENT'S NAME	GRADE	HOMEROOM TEACHER	DOB	HOME PHONE#	STUDENT'S EMAIL ADDRESS	STUDENT'S CELL#

**II. PARENT/GUARDIAN(S)**

**Mother/** Guardian Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Home Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer's Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Work Email \_\_\_\_\_

Spouse's Name (if not Father): \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**Father/** Guardian Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Home Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer's Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Work Email \_\_\_\_\_

Spouse's Name (if not Mother): \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**Student's primary residence is with:** Both \_\_\_ Mother \_\_\_ Father \_\_\_ Preferred primary email: \_\_\_\_\_

**EMERGENCY AND HEALTH INFORMATION**

MEDICATIONS BEING TAKEN	ALLERGIES / HEALTH CONCERNS	PREFERRED HOSPITAL / PHONE #

MEDICAL INSURANCE COMPANY	POLICY #

**III. AUTHORIZED PICK-UP AND EMERGENCY CONTACT INFORMATION**

Student will be released only to custodial parent(s) or legal guardian(s) and the person(s) listed below. The following people will be contacted and are authorized to pick up student if for some reason the custodial parent(s) or legal guardian(s) cannot be reached:

	NAME	RELATIONSHIP	HOME#	WORK#	CELL#
1.					
2.					
3.					

Persons who may **NOT** pick up student: \_\_\_\_\_

**PARENTAL CONSENT**

I authorize an adult representative of Warner Christian Academy (WCA) to consent to any and all medical and hospital care and treatment as deemed necessary for the health and well-being of my child by a duty-licensed physician selected by said adult representative. I understand that I shall be fully responsible for, and agree to pay for, all costs and expenses incurred in connection with such medical services rendered to my child pursuant to this authorization. Should it be necessary for my child to return home due to medical reasons or otherwise, I agree to assume all transportation costs. I give WCA permission to conduct vision, nutritional, and hearing screenings (K5 – 3<sup>rd</sup> and 6<sup>th</sup> grades) and scoliosis screening (6<sup>th</sup> grade). I agree to assume the risk of, and release WCA, its staff, and representatives from any and all injury and liability arising out of or relating to the activities conducted or sponsored by WCA. I state that the information on this form is correct.

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date