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)

**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 Father): _____ Cell Phone _____ Work Phone _____

**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 Mother): _____ Cell Phone _____ Work Phone _____

**Student's primary residence is with: _____Both _____Father _____Mother**

### *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 – 3rd and 6th grades) and scoliosis screening (6th 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

5-27-14 sp