

**WARNER CHRISTIAN ACADEMY PRESCHOOL**  
**EMERGENCY CONTACT/MEDICAL AUTHORIZATION**

Is student new to WCA? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has any information changed since enrollment? <input type="checkbox"/> Yes <input type="checkbox"/> No

**I. STUDENT INFORMATION**

Student's Last Name	First Name	Birth Date	Grade	Teacher

**II. PARENT/GUARDIAN INFORMATION**

**Mother/Guardian:** \_\_\_\_\_

**Father/Guardian:** \_\_\_\_\_

Spouse's Name (if not father): \_\_\_\_\_

Spouse's Name (if not mother): \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Address: \_\_\_\_\_

Address: (If different) \_\_\_\_\_

City/State: \_\_\_\_\_ Zip code: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Email Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

Work #: \_\_\_\_\_

Work #: \_\_\_\_\_

**Student's primary residence is with:**  Both  Mother  Father

**Which Parent/Guardian should be contacted first?**  Mother  Father  Other \_\_\_\_\_

**III. HEALTH INFORMATION**

Allergies/Health Concerns	Medication Being Taken	Medical Insurance Company

**IV. 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. **Photo I.D. is required.**

	Name	Relationship	Home #	Cell #	Work #
1.					
2.					
3.					
4.					
5.					

**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 cost 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 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 give WCA permission to conduct academic assessments as deemed necessary. I state that the information on this form is correct.

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

Date: \_\_\_\_\_