

# LIFE Christian Academy † A Child's LIFE

A Ministry of LIFE Fellowship

11500 North Sheridan Boulevard † Westminster, CO 80020-3302  
(303) 438-1260 † FAX (303) 438-1866

## STUDENT EMERGENCY REGISTRATION FORM

**IMPORTANT!**  
**FILL OUT ALL INFORMATION**

**PLEASE USE BLUE OR BLACK INK WHEN FILLING OUT THIS FORM.**

STUDENT NAME \_\_\_\_\_ AGE \_\_\_\_\_ GRADE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ GENDER \_\_\_\_\_

DAD \_\_\_\_\_ MOM \_\_\_\_\_

ADDRESS \_\_\_\_\_ ADDRESS \_\_\_\_\_

DAD'S HOME PHONE # \_\_\_\_\_ MOM'S HOME PHONE # \_\_\_\_\_

DAD'S CELL # \_\_\_\_\_ MOM'S CELL # \_\_\_\_\_

DAD'S WORK # \_\_\_\_\_ MOM'S WORK # \_\_\_\_\_

DAD'S EMPLOYER \_\_\_\_\_ MOM'S EMPLOYER \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_ WORK ADDRESS: \_\_\_\_\_

FAMILY E-MAIL ADDRESS \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE # \_\_\_\_\_

ADDRESS \_\_\_\_\_ CELL # \_\_\_\_\_

**AUTHORIZATION TO PICK UP (LIST THREE NAMES OF THOSE APPROVED TO PICK UP YOUR CHILD)**

NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

ADDRESS \_\_\_\_\_

NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

ADDRESS \_\_\_\_\_

NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

ADDRESS \_\_\_\_\_

**PLEASE CHECK ILLNESSES CHILD HAS HAD:**

RUBEOLA     RUBELLA     SCARLET FEVER     CHICKEN POX     MUMPS     EPILEPSY  
 DIABETES     POLIO     RHEUMATIC FEVER     STREP THROAT     HAY FEVER     WHOOPING COUGH

IS YOUR CHILD TAKING ANY DAILY PRESCRIBED MEDICINES?  YES  NO IF YES, EXPLAIN \_\_\_\_\_

MY CHILD IS ALLERGIC TO: \_\_\_\_\_

LIST ANY SURGERY'S , ACCIDENTS, CHRONIC ILLNESSES, OR SPECIAL PROBLEMS \_\_\_\_\_

PREFERRED HOSPITAL \_\_\_\_\_ PHONE # \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHYSICIAN NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

ADDRESS \_\_\_\_\_

MEDICAL INSURANCE CARRIER \_\_\_\_\_ POLICY # \_\_\_\_\_

DENTIST NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

ADDRESS \_\_\_\_\_

I ATTEST THAT ALL INFORMATION ON THIS FORM IS ACCURATE AND GIVE COMPLETE CONSENT TO THE STAFF OF LCA/A CHILD'S LIFE FOR COMPLETE EMERGENCY MEDICAL AUTHORIZATION IN CASE MY CHILD NEEDS MEDICAL ATTENTION WHETHER ON OR OFF CAMPUS. (UPDATED 10/17/2013)

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_