**Effective dates: 08/01/2019 to 5/31/2020**

**Please print in ink**

Name: Age: Birthday:

 Last First Middle

Year in school  Male  Female Email

Address City State Zip

Phone Cell

Medical insurance company Policy #

Mother’s name Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Home Work Cell

Father’s name Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Home Work Cell

Emergency contact Phone: Home Work

Physician Office phone

Dentist Office phone

**Medical History**

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which your child is subject and of which the staff should be aware, and what, if any action of protection is required on account thereof. Submit this notification in writing and attach it to this form. Include names of medications and dosages that must be taken.

**Check the following areas of concern for this student.** If necessary, add another page with details:

1. For your child’s safety and our knowledge, is your student a⎯

  good swimmer  fair swimmer  non-swimmer

2. Does your child have allergies to⎯

  pollens  medications  food  insect bites

 List all allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Does your child suffer from, or ever experienced, or currently being treated for any physical, mental, emotional

 disorder, or diagnosed learning disability?

 Explanation or diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please use the back further explanation.

4. Date of last tetanus shot:

5. Does your child wear  glasses  contact lenses

**Medications**

Current medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Student’s are not allowed to take any medication (prescription or non-prescription)**

**without the permission of one of the staff members of VCA.**

I give my permission to administer over the counter medication (Tylenol, Advil, sinus medication, etc…) to my child for minor complaints such as headache, sinus pain, etc. as approved by the VCA staff. \_\_\_\_\_Yes \_\_\_\_\_No

**Conduct**

## For your information, we expect each student to conform to the rules of the student handbook including:

 No possession or use of alcohol, drugs, **or tobacco**

 No fighting, weapons, fireworks, lighters, or explosives

 No offensive or immodest clothing

 Participation with the group is expected

 Respect property

 Respect one another, staff, and adult leaders

 Respect and comply with event schedules

**Students who fail to comply with these expectations may be sent home at their parents’ expense.**

I, the student, have read the rules of conduct, the above evaluation of my health, and permission to participate in youth group activities. I agree to abide by the stated personal limitations and code of conduct.

Student signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Note: If you desire to limit your child’s participation in any event, please submit your wishes in writing to the school office prior to that event.*

has my permission to attend all school activities

 Name of Student

sponsored by Victory Christian Academy from 08/01/19 to 05/31/20

This consent form gives permission to seek whatever medical attention is deemed necessary and releases the School and its staff of any liability against personal losses of named child.

I/We the undersigned have legal custody of the student named above, a minor, and have given our consent for him/her to attend events being organized by Victory Christian Academy. I/We understand that there are inherent risks involved in any ministry or athletic event, and I/we hereby release Victory Christian Academy, its pastors, employees, agents, and volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my/our child’s involvement. If he/she is injured and requires the attention of a doctor, I/we consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by Victory Christian Academy, I/we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I/We also acknowledge that we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. Further, I/we affirm that the health insurance information provided above is accurate at this date and will, to the best of my/our knowledge, still be in force for the student named above. I/we also agree to bring my/our child home at my/our own expense should they become ill or if deemed necessary by the Victory Christian Academy staff members.

Parent/guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_