



NAME:	Last	First	Middle Initial
AGE:	Birth Date (month/date/year)	Current Grade	
PARENT/GUARDIAN'S NAME:			
ADDRESS:	Street/P.O. Box		
ADDRESS:	City	State	Zip Code Country
HOME #:	Cell #:		
If parent/guardian are not available, please contact:			
Emergency Name:	Phone:	Cell:	
Emergency Name:	Phone:	Cell:	
<u>MEDICAL HISTORY</u> (Attach a recent copy of your child's immunization records)			
Doctor's name:	Phone:		
Medical Insurance Company :	Policy #:		
List allergies to any foods or medication: _____			
Please list any medical problems, including the diagnosis: _____ _____			
Is your child currently on any medication, including inhalers? Yes _____ No _____ If yes, name of medication _____. If yes, does the medication need to be taken during program hours? Yes ___ No ___ If yes, written permission from a parent or guardian must accompany the medication, which must be <u>self-administered</u> .			
<u>EMERGENCY RELEASE:</u> I give permission, in the event of an emergency, for first aid to be administered to my child, and should it be necessary, for emergency medical treatment, which may include transportation by ambulance to the nearest hospital. I understand that every effort will be made to contact me.			
Parent/Guardian Signature: _____			Date: _____
<u>PROGRAM AND PHOTO RELEASE:</u> I give my permission for my child to participate in all program activities. The Leadership Academy includes field trips and weekend activities. If there are any known activities for which your child cannot participate, please list them here: I also give permission to allow my child's photographs and/or videotapes to be taken during this program, and that they may be published and used by At The Well Conferences, Inc. to promote its programs.			
Parent/Guardian Signature: _____			Date: _____