

LWA

Living Way Academy

2020-2021 Registration Form

Student Info

Student Name: _____ DOB: _____ Grade: _____ R: _____ () T: _____ ()

Student Name: _____ DOB: _____ Grade: _____ R: _____ () T: _____ ()

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Student Name: _____ DOB: _____ Grade: _____ R: _____ () T: _____ ()

Parent Info

Father's Name: _____ Email Address: _____

Home Address: _____ City: _____ Zip: _____

Employer: _____ City: _____

Cell Phone: _____ Work Phone: _____

Mother's Name: _____ Email Address: _____

Home Address: _____ City: _____ Zip: _____

Employer: _____ City: _____

Cell Phone: _____ Work Phone: _____

In the event of an emergency, students WILL NOT be released to an individual not listed on emergency forms. NO EXCEPTIONS. Photo ID is required to pick up the student from school. List other persons authorized to be contacted in the event of an emergency or to pick up students from school when the above parent/guardian cannot be reached below.

Emergency Contacts

Contact Name: _____ Relationship to Student: _____

Cell Phone: _____ Email Address: _____

Contact Name: _____ Relationship to Student: _____

Cell Phone: _____ Email Address: _____

Contact Name: _____ Relationship to Student: _____

Cell Phone: _____ Email Address: _____

Contact Name: _____ Relationship to Student: _____

Cell Phone: _____ Email Address: _____

Contact Name: _____ Relationship to Student: _____

Cell Phone: _____ Email Address: _____

Medical Info

Medical Conditions/Allergies – all medications must remain in the office with signed consent forms.

Condition/Allergy: _____

Medications Required: _____

Special Instructions: _____

Condition/Allergy: _____

Medications Required: _____

Special Instructions: _____

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Medications Required: _____

Special Instructions: _____

Physician Name : _____

Physician Phone: _____

Hospital Preference: _____

Dentist Name: _____

Dentist Phone: _____

Dental Office: _____

Medical Coverage Plan: _____

Medical Policy Holder: _____

Dental Coverage Plan: _____

Dental Policy Holder: _____

Medical Record Number & Student Name: _____

Medical Record Number & Student Name: _____

Medical Record Number & Student Name: _____

Medical Record Number & Student Name: _____

Insurance Info

Extended Care (EC) fees are \$3.00 per hour, per student. There is a \$3.00 per minute fee after 6:00 p.m.

that must be paid to staff upon late arrival. If fee is not paid that day, EC privileges will be suspended until fees are paid.

Extended Care Info

My student will utilize the following EC (select all that apply):

- ☐ Morning EC on the first day of school only
- ☐ Afternoon EC on the first day of school only
- ☐ Morning EC from 6:30 a.m. – 7:15 a.m., Monday-Friday
- ☐ Afternoon EC from 2:45 – 6:00 p.m., Monday-Friday
- ☐ Periodically, when needed

Authorization for Medical Treatment of a Minor

(We), the undersigned, parent(s) of the student(s) listed on this application, do hereby authorize Living Way Academy, kindergarten through 12th grade, its adult agents and employees, into who care said minor(s) has been entrusted to while traveling to and from and while attending Living Way Academy outings sponsored by Living Way Academy, to consent to any x-ray examination, anaesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to said minor under the general or special supervision and upon advice of a physician or surgeon licensed under the provision of the Medical Practice Act, or to any x-ray examination, anaesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to said minor under the general or special supervision and upon advice of a dentist licensed under the provision of the Dental Practice Act.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but it is given to provide authority and power on the part of the Living Way Academy and its adult agents and employees to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician or dentist in the exercise of his/her best judgement made deem advisable.

This authorization is given pursuant to the provision of section 25.8 of the Civil Code of California. This authorization shall remain as long as the student(s) is/are enrolled, unless sooner revoked in writing delivered to said agent(s). The undersigned is a person (s) that has legal custody or is/are the legal guardian(s) of said minor(s).

Any ambulance transportation is the sole financial responsibility of the recipient or guardian thereof and not the financial responsibility of Living Way Academy.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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Request for School Records

Please send cumulative records to the requesting school for the student(s) below to:

Living Way Academy
ATTN: Registrar
16725 Valencia Avenue
Fontana, CA 92335
(909) 823-4404

Please include the following: original transcripts, birth certificate(s), immunization records, health records, and any IEP and/or 504 documents (if applicable).

☐

I authorize a representative from Living Way Academy to physically pick up requested items, if available.

Student(s) Information

Last: _____ First: _____ Middle Int.: _____ DOB: _____

Last: _____ First: _____ Middle Int.: _____ DOB: _____

Last: _____ First: _____ Middle Int.: _____ DOB: _____

Last: _____ First: _____ Middle Int.: _____ DOB: _____

Name of previous school attended: _____

Address: _____

Parent/Guardian Signature: _____ Date: _____

Principal/Designee Signature: _____ Date: _____