



# United Faith Christian Academy

Christ-centered • College Prep • PreK -12<sup>th</sup> Grade

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Email: [admissions@ufca.org](mailto:admissions@ufca.org)

## 2019-20 Medical Information and Emergency Release Form

**Please note:** Parent must complete this form and return to the UFCA Academy Office no later than August 1, 2019. All information must match what is in Sycamore. Emergency This form is required to be on file before the student will be allowed to attend school.

Student Name \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First Middle Preferred

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender (please circle) M F Student Cell # \_\_\_\_\_ Grade *Entering* \_\_\_\_\_

### FAMILY INFORMATION (please print clearly in black or blue ink)

	Name	Legal Guardian	Cell Number	Work Number
Mother		Y/N		
Father		Y/N		
Step-Parent		Y/N		

### EMERGENCY CONTACTS (Two more contacts, other than listed above, are required. Additional contacts continue on back of form.)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone(s): H: \_\_\_\_\_ W: \_\_\_\_\_ C: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone(s): H: \_\_\_\_\_ W: \_\_\_\_\_ C: \_\_\_\_\_

	Name	Phone
Pediatrician/ primary care provider		
Hospital of choice		
Dentist		

Insurance: \_\_\_\_\_ Plan/Group #: \_\_\_\_\_ Phone: \_\_\_\_\_

*(In case of accident or serious illness, the school will attempt to contact the parent/guardian. If the school is unable to contact the parent/guardian or person designated above, the school will make necessary arrangements for immediate treatment. Payment of any fees will be assumed by the parent/guardian.)*

I hereby give my consent to any hospital and/or licensed physician or authorized provider to administer necessary emergency treatment to my child in the event such treatment is imperative and I cannot be contacted.

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

Parent/Guardian Name: (please print) \_\_\_\_\_

### HEALTH HISTORY

List any health information (past and present, such as diabetes, asthma, allergies, seizures, migraines, AD/ADHD, etc.) \_\_\_\_\_

**Please Note:** The following 4 conditions require an **Emergency Action Plan** (or similarly named document) **from your doctor's office**, signed by parent/guardian **and doctor**:  Asthma  Diabetes  Seizures  Allergies that may require an EpiPen

Does your child currently take any medications?  No.  Yes. (If yes, please list.) \_\_\_\_\_

If yes, do the medication(s) need to be administered during school?  No.  Yes. (If yes, a required, doctor-signed Authorization to Administer Medications must be submitted. Form provided in Academic Office or at [www.ufca.org](http://www.ufca.org) under Parent Resources / Medical Forms)