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Main Campus: 1105 N. Lakewood Avenue · Ocoee, FL · 34761  
South Campus: 1450 Citrus Oaks Avenue, #400 · Gotha, FL · 34734

### 2023-2024 Academic Year - Permission and Medical Consent

As parent/guardian, I hereby give permission for my child to participate in activities that are organized by LIGHT Christian Academy.

**Child's Full Name:** \_\_\_\_\_

Sex: \_\_\_\_\_ Last Date of Birth: \_\_\_\_\_ First Age: \_\_\_\_\_ Middle Race/Ethnicity: \_\_\_\_\_

**Name of Parent/Guardian:** \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

**Emergency Contact #1:** \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

**Emergency Contact #2:** \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

In case of minor headache or stomachache, I authorize Light Christian Academy to give my K-12<sup>th</sup> grade child the following medication:

Ibuprofen    Aspirin    Tylenol    Children's Tylenol    Tums    Pepto-Bismol    Nothing

Does your child have any allergies   NO \_\_\_\_\_   YES \_\_\_\_\_

If yes, please explain below:

\_\_\_\_\_

Does this child have any medical or health problems or has this child had any chronic or recurring illness, which may affect their participation in activities?

\_\_\_\_\_

Are there any activities, such as strenuous activities, that should be restricted for this child?

No \_\_\_\_\_ Yes \_\_\_\_\_ Describe: \_\_\_\_\_

Describe any dietary restrictions child is required to observe:

\_\_\_\_\_

Is this child on any medications? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, list all medications below:

\_\_\_\_\_

Name of Child's Physician: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

If child has current medical insurance, please indicate below:

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Name of insured: \_\_\_\_\_

Date of last tetanus Shot: \_\_\_\_\_

I, \_\_\_\_\_, understand that the LIGHT Christian Academy and Childcare carries medical/hospitalization insurance which consistent with the exclusions, limitations and term thereof, may provide benefits above any personal medical/hospitalization insurance available to my family. I understand that any personal medical/hospitalization insurance will provide primary coverage and the LIGHT Christian Academy and Childcare medical/hospitalization coverage may provide secondary or excess coverage. I agree to apply first the benefits from the personal medical/hospitalization available to me before applying for benefits that may be available from LIGHT Christian Academy and Childcare. I further understand that in the event my child requires medical treatment while engaged in the above named activity, reasonable efforts will be made to contact me. If I cannot be reach, I hereby consent and give permission to the LIGHT Christian Academy and Childcare sponsor or any LIGHT Christian Academy and Childcare Adult Counselor to act as an agent for me to consent to any x-ray, injections, anesthesia, medical or surgical physician, licensed to practice under the laws of the state were the services are rendered, either as an outpatient or in patient stay. **My child has permission to participate in all prescribed activities except as noted by me.**

Signature of Parent/Guardian: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

Date Witnessed: \_\_\_\_\_

This form is valid for one (1) year from the date signed above. A 'field trip permission form' must be signed for all off site activities. It is the responsibility of the parent/guardian to update information as needed.