



1450 Citrus Oaks Avenue · Gotha, FL · 34734

www.mylcac.com

2025-2026 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 _____ First _____ Middle _____
Date of Birth: _____ Age: _____ 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-12th 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.