

**Wedgwood Academy
Registration Form**

STUDENT INFORMATION:

Full name of student _____

Preferred first name _____ **Grade (2018-2019)** _____
Birthdate ____/____/____ **Gender** ___Male ___Female

PARENTS: Married ___ Separated ___ Divorced ___

PARENT/GUARDIAN INFORMATION:

Dr./Mr./Mrs./Ms. _____
Home address _____

City _____ **Zip code** _____

Email address _____

Home phone _____

Cell phone _____

Company name _____

Occupation _____

Work phone _____

PARENT/GUARDIAN INFORMATION:

Dr./Mr./Mrs./Ms. _____
Home address _____

City _____ **Zip code** _____

Email address _____

Home phone _____

Cell phone _____

Company name _____

Occupation _____

Work phone _____

SIBLING INFORMATION - AGE, SCHOOL ATTENDING:

1. _____
2. _____
3. _____

OTHER PEOPLE WITH PERMISSION TO PICK STUDENT UP:

1. _____
2. _____

PLEASE LIST ANY MEDICATIONS YOUR CHILD IS TAKING AT HOME: _____

AS PRESCRIBED BY A DOCTOR, MY CHILD IS TO TAKE THE FOLLOWING AT SCHOOL:

I GIVE MY PERMISSION FOR WEDGWOOD ACADEMY TO ADMINISTER MY CHILD'S MEDICATION AS IS DIRECTED ON THE MEDICINE BOTTLE.

PARENT SIGNATURE _____

IF YOUR CHILD HAS ANY ALLERGIES, PLEASE LIST BELOW: _____

As parent(s) of a student enrolled at Wedgwood Academy, I have read and agree to the school policies. I will communicate regularly with the school to encourage the progress of my student. I will provide testing records to facilitate academic evaluation and support the judgment of the school in academic placement. I will be responsible for supervising homework assignments and will assist in organization and study skills. I have received a copy of, understand and support the discipline system of the school. I will explain policies, goals, etc. to my child and expect his (her) support of them.

Parent signature _____

WEDGWOOD ACADEMY HAS PERMISSION TO PHOTOGRAPH MY CHILD FOR PRINTED AND ELECTRONIC MATERIALS.

I GIVE MY CHILD PERMISSION TO ATTEND FIELD TRIPS DURING THE SCHOOL YEAR.

Students will not be allowed to participate in any school activities until this form is completed and on file at Wedgwood Academy.

2018– 2019 LIABILITY RELEASE

Student's name: _____
Grade (2018-2019) _____ **Date of Birth** _____

Authorization is hereby granted, by the undersigned, to Wedgwood Academy, its representatives or its agents, under any circumstances considered to be an emergency by Wedgwood Academy to transport the above named student to any hospital, clinic, or physician's office and to agree to and sign for any emergency medical treatment deemed necessary. The under signed further agrees to pay for all medical expenses associated with such emergency medical treatment and further releases from liability and agrees to hold harmless Wedgwood Academy from any and all suits, claims, causes of action or demands of any kind or character whatsoever arising out of any damage, injury, or death occasioned at Wedgwood Academy, or activities under its supervision, and during travel to and from any such activities or emergency medical treatment as authorized under this release or at the hospital, clinic, or physician's office during treatment.

I hereby give my consent for the above named student to participate in School approved sports or activities, and travel with the coach or other representative of the school on any trips.

I have set out below any special concerns that I have regarding participation in any school activity in which I would like to limit the above named student.

The undersigned further acknowledges familiarity with the dangers involved to the above named student in school events, athletic or recreational.

I have set out below certain medical conditions of the above named student that are known to me which may be of importance should the above named student require medical attention.

Parent signature _____

IN CASE OF EMERGENCY IN WHICH THE PARENTS CANNOT BE REACHED, PLEASE CALL:

NAME	RELATIONSHIP	PHONE
#		
1.	_____	_____
2.	_____	_____

WEDGWOOD ACADEMY HAS PERMISSION TO ADMINISTER:

_____ **IBUPROFEN (ADVIL)** _____ **ACETAMINOPHEN (TYLENOL)**
_____ **OTHER** _____

AT THE DISCRETION OF THE DIRECTOR AS DEEMED NECESSARY TO MY CHILD DURING SCHOOL HOURS.

IF SUCH AN EMERGENCY ARISES WHERE TREATMENT AT A HOSPITAL, CLINIC, OR PHYSICIAN'S OFFICE IS NECESSARY, PLEASE CONTACT THE FOLLOWING:

PHYSICIAN _____
ADDRESS _____
PHONE NUMBER _____

PREFERRED HOSPITAL OR CLINIC TO BE USED:

NAME _____
ADDRESS _____
PHONE NUMBER _____

PRIMARY INSURANCE COVERAGE

COMPANY NAME _____
NAME OF INSURED _____
PHONE NUMBER _____
GROUP/POLICY NUMBER _____

THIS IS A RELEASE AND MEDICAL TREATMENT FORM. IF ANY CHANGE OCCURS IN THE ABOVE INFORMATION, NOTIFY THE SCHOOL IMMEDIATELY.

PARENT SIGNATURE: _____

PARENT SIGNATURE: _____