

Please complete for your child:

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_

Grade \_\_\_\_\_



# Legacy Academy

## Registration Form

Post Office Box 409 De Queen, Arkansas 71832, (870)642-8937 [www.legacyacademyonline.com](http://www.legacyacademyonline.com)

Please print or type and return to Legacy Academy. If you have not yet done so, you must include a copy of the child's birth certificate and current immunization record.

### Personal Information

Student's Name \_\_\_\_\_

Last

First

Middle

Parent / Guardian Home Phone: \_\_\_\_\_

Cell: \_\_\_\_\_

Office: \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

### Extended Care Information (Preschool Only)

Student will need extended care before school (7am-8am)\*  yes  no

Student will need extended care after school (3pm-5pm)\*  yes  no

*Note: Extended care option is extended to Preschool students.  
Preschool tuition includes extended care for Preschool students*

### Emergency Contact Information

Please list two Emergency contacts in the event that parents or guardians cannot be reached:

Last Name, First Name \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Last Name, First Name \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

## Authorized Pick-Up Information

Please list all persons you authorize to pick up your child from school:

Last Name, First Name \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Last Name, First Name \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Last Name, First Name \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

## Medical Information

Child's Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

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

## Allergies, Medications, and Medical History

Please list all of the student's daily and weekly medications:

Taken during the school day:

1. \_\_\_\_\_

yes  no

2. \_\_\_\_\_

yes  no

3. \_\_\_\_\_

yes  no

4. \_\_\_\_\_

yes  no

5. \_\_\_\_\_

yes  no

I hereby give \_\_\_\_\_/do not give \_\_\_\_\_ the Director of the Legacy Academy or an appointed representative permission to give my child acetaminophen. I understand I will be notified that the medication has been administered.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Please list all of the student's known allergies and a brief medical history (chronic conditions, diseases, etc):

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**\*\*Student's current immunization records must be turned in before student can be enrolled\*\***

**\*\*A copy of the student's Birth Certificate must be turned in before student can be enrolled\*\***

