
# Enrollment Form

_____
*Last Name, First Name*

## FAMILY INFORMATION

Date: _____

Student's Name: _____ Nickname (if any): _____

Student's Birth Date: _____ - _____ - _____ Male: _____ Female: _____

| **Primary Contact** | **Secondary Contact** |
|---|---|
| Name: _____ | Name: _____ |
| Relationship to child: _____ | Relationship to child: _____ |
| Address: _____ | Address: _____ |
| City, State, Zip: _____ | City, State, Zip: _____ |
| Student lives at this address: _____ Yes _____ No | Student lives at this address: _____ Yes _____ No |
| Home Phone: _____ | Home Phone: _____ |
| Cell Phone: _____ | Cell Phone: _____ |
| Work Phone: _____ | Work Phone: _____ |
| Employer: _____ | Employer: _____ |
| Work Address: _____ | Work Address: _____ |
| City, State, Zip: _____ | City, State, Zip: _____ |
| Member of WOLCC? _____ Yes _____ No | Member of WOLCC? _____ Yes _____ No |
| Email Address: | Email Address: |

| | |
|---|---|
| Periodically Word of Life Academy may send out an email blast. Please indicate whether or not you are interested in being on our list.<br>_____ I want to be on the list<br>_____ I don't want to be on the list | Periodically Word of Life Academy may send out an email blast. Please indicate whether or not you are interested in being on our list.<br>_____ I want to be on the list<br>_____ I don't want to be on the list |
| Periodically Word of Life Academy may sent out an automated phone call. Which number is the best way to contact you?<br>_____ Home _____ Cell _____ Work | Periodically Word of Life Academy may sent out an automated phone call. Which number is the best way to contact you?<br>_____ Home _____ Cell _____ Work |

For Administrative use only- _____ $75.00 Reg. fee _____ Class Placement
Date: Time: Taken by:


_____
***Last Name, First Name***

# STATEMENT OF AUTHORIZATION

***Please initial the following:***

_____ My child has permission to watch taped educational TV programs and videos as the Word or Life Academy teachers deem appropriate.

_____ My child has permission to go on supervised walking field trips away off of school property. Notice will be given for field trips further than one mile from the school.

_____ I give permission for the use of any photograph or video representation of my child/children in news releases, brochures, or for other public relations purposes.

## Emergency Contact Information

**In the event of illness or an emergency, we will try to contact a parent first.** If we are unable to reach either parent, we will attempt to call a contact listed below. Please list anyone you would like for us to contact, and include any persons that might pick up your child for carpool, or in the event of illness or an emergency.

| Order of Preference | Name | Phone Number | Address | Relationship to Student | Authorized for pick up? |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |

Only those persons marked are authorized to pick up my child from school. I understand that my child will not be released to anyone on this form without prior consent. In the event of an emergency, I can give verbal authorization to the school to add a person to this form, who will then be required to show proof of identification.

Parent Signature Date

8700 E. Park Meadows Drive ● Lone Tree, CO 80124 ● 303-785-6115 ● 303-798-7368 fax ● www.wolcc.net/academy

Wol Academy

_____
*Last Name, First Name*

# MEDICAL INFORMATION

Doctor's Name: _____ Name of Practice: _____

Address: _____ Phone Number: _____

Dentist's Name: _____ Name of Practice: _____

Address: _____ Phone Number: _____

Please list any allergies or medical concerns:

**If my child needs emergency, medical attention, my child should be take to the following hospital:**

_____ **Children's Hospital**
1056 E. 19th Avenue
Denver, CO 80218
303-861-8888

_____ **Parker Adventist Hospital**
9395 Crown Crest Blvd.
Parker, CO 80138
303-269-4000

_____ **Skyridge Medical Center**
10101 Ridgegate Parkway
Lone Tree, CO 80124
720-225-1000

_____ **Other** (please list name, address, phone number below):

_____ **Porter Adventist Hospital**
2525 S. Downing
Denver, CO 80210
303-778-1955

_____ **Swedish Medical Center**
501 E. Hampden Avenue
Englewood, CO 80110
303-788-5000

_____ **Littleton Adventist Hospital**
7700 S. Broadway
Littleton, CO 80122
303-730-8900

_____ **No Preference**

I hereby give permission to Word of Life Academy to call an emergency team, doctor or other medical person or organization or surgical care for my child or to have my child taken to a hospital should the need arise. If time permits, I understand that an effort will be made to locate me or my spouse before any action will be taken. If we cannot be contacted, any expense incurred by the school will be accepted by the undersigned.

Parent Signature Date