



## Shadow Day Emergency Form

### STUDENT INFORMATION

Last Name	First	Middle	Birth Date	Age	Current Grade
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### PARENT/GUARDIAN INFORMATION

Father/Guardian	Cell Phone	Work Phone	Email
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Mother/Guardian	Cell Phone	Work Phone	Email
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Home Address

Does your child have any known allergies or medical conditions we should be aware of? If yes, please detail here:

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Insurance : \_\_\_\_\_ Phone: \_\_\_\_\_

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

Hospital Preference: \_\_\_\_\_

Agreement and Release from Liability: I hereby agree to indemnify and hold harmless Living Rock Academy, its officers, directors, and employees, from and against any and all liability or injuries which my child may suffer arising out of or in any way connected with my child's participation in this program. In case of emergency, arising during or in connection with any activity, I authorize any person in charge of the activity to consent to emergency treatment, at my expense. I understand that Living Rock Academy is not obligated to carry any insurance to cover medical and/or dental treatment for my child. I agree to pay any needed medical and/or dental expenses incurred by Living Rock Academy.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_