

Please complete for your child:

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

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

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

Grade: \_\_\_\_\_

Enrollment Date: \_\_\_\_\_



# Legacy Academy Registration Form

314 West Gilson Avenue, 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 Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

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

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

Work Hours: \_\_\_\_\_

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

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

## 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:

#1.

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

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

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

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

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

#2.

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

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

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

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

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

#3.

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

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

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

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

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

## Allergy & Medical Records

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

Please list all of the student's known allergies:

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**CHILD'S PHYSICIAN**

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_

**\*\*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\*\***