



LCA - Athletic Health Form 2024 - 2025

Athlete's Full Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Athlete's Cell/Provider: _____/_____

Father's Name: _____ Father's Cell/Provider: _____/_____

Mother's Name: _____ Mother's Cell/Provider: _____/_____

Father's Work: _____ Mother's Work: _____

*Emergency Contact: _____ Phone: _____

*(If a parent/guardian CANNOT be reached.)

Allergies: No Yes, please specify: _____

Diabetic: No Yes, please specify: _____

Asthma: No Yes, please specify: _____

Convulsive Disorder: No Yes, please specify: _____

Tetanus Shot: Last date received: _____

Other medical conditions that LCA should be made aware: _____

Student's Physician: _____ Phone: _____

Prescribed Medications: No Yes, please specify: _____

Exercise Restrictions: No Yes, please specify: _____

Insurance Company: _____

Policy Holder's Name: _____

Group Number: _____ Policy Number: _____

I/we agree to hold **Legacy Christian Academy** and its agents harmless of any liability resulting from injuries sustained during any sports activity, school function, or loss of property. I/we give consent for my student to receive medical treatment when deemed necessary by the Athletic Director or **LCA** Personnel.

I/we agree to support **Legacy Christian Academy's Athletic & Boosters Program**. I/we will volunteer to work at the admissions gate and concession stand throughout the season(s) my student(s) participates. If I/we are unable to work the date assigned, it is our responsibility to trade with another parent/guardian. I/we know that this is vital to our program helping to cover the costs of equipment, uniforms, officials, etc.

Print Parent/Guardian's Name: _____ Signature: **x** _____

Date: _____ Email: _____

Print Parent/Guardian's Name: _____ Signature: **x** _____

Date: _____ Email: _____

