# The Light Academy

479 Cunningham Rd.
Palmyra, Virginia 22963
434-806-2903/434-842-2222
www.thelightacademy.com

*For Office Use Only*

*Date Received:* _____

*Registration Fee*: _____

_____

## 2026 - 2027 AFTER-SCHOOL Registration Form

First Student's Full Legal Name: _____
Preferred Name: _____ Date of Birth: _____
Gender: _____ Grade Entering: _____
Allergies or Medical Concerns: _____
_____

Second Student's Full Legal Name: _____
Preferred Name: _____ Date of Birth: _____
Gender: _____ Grade Entering: _____
Allergies or Medical Concerns: _____
_____

Third Student's Full Legal Name: _____
Preferred Name _____ Date of Birth: _____
Gender: _____ Grade Entering: _____
Allergies or Medical Concerns: _____
_____

Student(s) live with:
____ Mother _____Father ____Other(Please Specify) _____
Religious Denomination: _____Church attending: _____

**Parent/Guardian Information – Father (please print)**
Name: _____

Home/Cell Number: _____ May we send you texts? _____yes _____no

Email: _____

Home Address: _____

Mailing Address (if different):_____

Place of Employment: _____

Address of Place of Employment:_____

Work Number: _____

**Student(s) last name: _____**

**Parent/Guardian Information – Mother (please print)**
Name: _____

Home/Cell Number: _____ May we send you texts? _____yes _____no

Email: _____

Mailing Address: _____

Place of Employment: _____

Address of Place of Employment: _____

Work Number: _____

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Please list **emergency contact persons** who are authorized to pick up your child in the event we are unable to reach the parent/guardian(s) above:
Name: _____

Phone Number: _____ Relationship to the student(s):_____

Address: _____

Name: _____

Phone Number: _____ Relationship to the student(s):_____

Address: _____

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**Other people who are authorized to pick up your child from school**: (for playdates, transportation, etc.)
Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

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**Physician**: _____ **Physician's Office Number:** _____
In the event of an emergency, I authorize a staff member of The Light Academy to seek medical attention for my child(ren).

_____ Date: _____
Parent/guardian signature

_____
Parent/guardian name printed

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Does your child have an Individual Education Plan (IEP), Individual Service Plan (ISP), or a 504 Plan?
_____ yes _____no

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Please list any additional information about your child(ren) that would help us as we work with your child(ren)

_____

_____

Student(s) last name: _____

## Schedule Options:

_____ monthly commitment billed regardless if your child(ren) is sick or doesn't attend (This monthly amount is $7.00 / day per child. It will be pro-rated on shorter months due to holidays and breaks.)

OR

_____ charged for only the days your child(ren) attends (This rate is $10.00/day per child and billed at the end of the month.)