School Year: 2020-2021
Date: 07/27/2020

Enrolled Student Information Sheet

Please be patient after submitting the form as it may take time to process. You will receive a notice that an email has been sent.

Fill out for another child

Submit completed form BEFORE filling out for another child.

For your child's benefit, please keep us informed of any changes

Student Information:

First Name | Middle Name | Last Name | Preferred Name

StreetAddress | Date of Birth

City | State | Zip | County

Resides With | School District

---

*The **Emergency Alert System** is a notification system used in case of weather closure or other urgent notifications.
AT LEAST 1 number must be used for the Alert System.

Parent / Guardian 1:

Please list as much information as possible, so that we may reach you in case of emergency

Relation to Student: ◯ Parent ◯ Adoptive Parent ◯ Step-Parent ◯ Guardian

Title | Name

Same As Above | Street Address

City | State | Zip

Place of Employment (if applicable)

*Use for Emergency Alert System? Y

Home Phone:
Cell Phone: ✔
Work Phone:
Email (H): ✔
Email (W):

Parent / Guardian 2:

Relation to Student: ◯ Parent ◯ Adoptive Parent ◯ Step-Parent ◯ Guardian

Title | Name

Same As Above | Street Address

City | State | Zip

Place of Employment (if applicable)

*Use for Emergency Alert System? Y

Home Phone:
Cell Phone:
Work Phone:
Email (H):
Email (W):

Parent/Guardian Notes:

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SchoolYear: 2020-2021

Enrolled Student Information Sheet

Parent or Legal Guardian Information

Parents of Student - Marital Status to each other:

◯ Married ◯ Divorced ◯ Separated ◯ Single

Mother's Custody Rights ☐ NA ☐ Full ☐ Joint ☐ Visit ☐ None

Father's Custody Rights ☐ NA ☐ Full ☐ Joint ☐ Visit ☐ None

Notes:

Additional Emergency Contacts (other than parent)

All persons listed have permission to pick up my child unless noted

PLEASE PROVIDE AT LEAST 1 Additional Emergency Contact Name and Phone

1. Name: Relation to Student:

Y Use for the Emergency Alert System?

Cell Phone: ☐
Home Phone: ☐
Work Phone: ☐
Email: ☐

Notes:

2. Name: Relation to Student:

Y Use for the Emergency Alert System?

Cell Phone: ☐
Home Phone: ☐
Work Phone: ☐
Email: ☐

Notes:

3. Name: Relation to Student:

Y Use for the Emergency Alert System?

Cell Phone: ☐
Home Phone: ☐
Work Phone: ☐
Email: ☐

Notes:

Additional Information

Student's Birth Order with Regard to Other Siblings

◯ 1st ◯ 2nd ◯ 3rd ◯ 4th ◯ 5th ◯ Other

Completed Education:

MOTHER	FATHER
☐ High School or Less	☐ High School or Less
☐ 1-3 Years of College	☐ 1-3 Years of College
☐ Undergraduate Degree	☐ Undergraduate Degree
☐ Graduate Degree	☐ Graduate Degree
☐ Beyond Graduate Degree	☐ Beyond Graduate Degree
☐ Doctoral Degree	☐ Doctoral Degree
☐ Medical Degree	☐ Medical Degree

Notes:

Check All That Apply:

☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American
☐ Asian
☐ White
☐ Hispanic or Latino
☐ Native American or Alaskan Native
☐ Other:

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School Year: 2020-2021

Enrolled Student Information Sheet

DISMISSAL INFORMATION

Additional persons authorized for pick-up

In addition to contacts already listed, the following individuals are authorized to pick-up my child:

Name	Relation To Child	Phone

Are there restrictions regarding a parent's right to pick-up? ◯ YES ◯ NO

Legal Documentation Required
Please Provide Details Below:

Regular Dismissal Plan:

☐ Pick up by parent / guardian ☐ Every Day ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ As Needed

☐ Pick up by other ☐ EveryDay ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ AsNeeded

☐ Carpool with ☐ EveryDay ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ AsNeeded

Child's Name:

Date: 07/27/2020

Parent Signature:

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MEDICAL EMERGENCY FORM

In case of an emergency, when we cannot be contacted, my child,

_____ may receive medical treatment from

_____ (physician) and/or

_____ (hospital).

We will be responsible for any charges related to the emergency medical treatment.

07/27/2020
Date

_____
Parent or Legal Guardian Signature

Hospitalization Coverage:

Company: _____

Policy Number: _____

Student Medical Information

Note: The MEDICATION PERMISSION FORM must be completed if you wish for your child's teacher to administer any medication during school hours.

1. Chronic medical conditions (asthma, seizures, diabetes, etc.) ◯ YES ◯ NO

   Describe: _____

2. Food allergies ◯ YES ◯ NO

   Describe: _____

3. Other allergies ◯ YES ◯ NO

   Describe: _____

Please complete the attached EMERGENCY PLAN as needed

Audiology Information

Is your child is under the care of an audiologist? ◯ YES ◯ NO

Audiologist's name: _____

Place of Employment: _____

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Emergency Plan

Name: Date: 07/27/2020

- ○ No Emergency Plan is Needed
- ○ Emergency Plan Completed Below

Reason for Plan:

Reaction to look for:

Emergency Action:

Medication:

Location of Medication: (Completed by Teacher)

Parent signature | Teacher signature | date

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School Year: 2020-2021

DUBARD SCHOOL FOR LANGUAGE DISORDERS
MEDICATION INFORMATION

Student's First Name: _____ **Last Name:** _____

I. Please check one of the boxes

My child: ◯ **Takes medication daily**

◯ **Does NOT take medication daily**

II. Please fill out the following information concerning ALL medications your child takes.

A. Medication taken at HOME:

Medicine	Each Dosage (Include mg.)	Time for Each Dosage	Physician

B. Medication taken at SCHOOL:

Medicine	Each Dosage (Include mg.)	Time for Each Dosage	Physician

III. I give permission to the personnel of the DuBard School for Language Disorders to administer the medication listed below to my child:

Medicine:	
Dosage:	
Time:	
Other instructions:	
Physician:	
Beginning Date:	

IF THERE ARE CHANGES IN DOSAGE OR NEW MEDICATIONS GIVEN AT HOME OR SCHOOL, I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO NOTIFY THE SCHOOL IN WRITING AND COMPLETE A NEW MEDICATION INFORMATION FORM

Date 07/27/2020 Parent's Name _____

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Consent and Release of Liability
for Photograph, Audio and Video Recording

The University of Southern Mississippi
DuBard School for Language Disorders

I _____ parent of _____, a minor child, do hereby give The University of Southern Mississippi DuBard School for Language Disorders and its representatives my full permission to photograph, video record, copyright, reproduce, telecast or cablecast, use on the internet, publish or otherwise use my child's photograph, likeness, video or audio recording for the creation of educational and/or promotional programs or for any other purposes which support the mission of the school.

It is understood that The University of Southern Mississippi DuBard School for Language Disorders and aforementioned parties may use this material at its discretion, but that this consent shall not obligate the school to use any material obtained.

I hereby waive any right to inspect or approve the use of the images or recordings or of any written copy. I also waive the right to royalties or other compensation arising from or related to the use of the images, recordings or materials.

I further release, defend, indemnify and hold harmless The University of Southern Mississippi DuBard School for Language Disorders, its advisory board, agents, officers, employees or other representatives from and against any claims, damages or liabilities, known or unknown, arising out of the use of this material, including copyright infringement, or any misuse, distortion, blurring, alteration, optical illusion or use in composite form that may occur or be produced in taking, processing, reduction or production of the finished product, its publication or distribution.

It is further understood that my child's name will not be used by The University of Southern Mississippi DuBard School for Language Disorders within any created program or material without my further consent and approval, with the exception of news releases on school activities, and use of first name on special projects and social media.

I further understand that my child's picture and name will be included in a school yearbook that will be distributed among DuBard School students and staff. Video footage of my child may be included in a video recording and telecast of the Awards Day program unless I give written notification of my decision to opt out of these opportunities.

I certify that I have read this document and fully understand its terms and conditions and that I have full legal capacity to sign on behalf of my child.

_____
Child's Name

_____ _____
Name of Custodial Parent or Guardian *Initials of Parent or Guardian

_____ 07/27/2020
Relationship to Child Date

revised 8-21-18

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THE UNIVERSITY OF
SOUTHERN MISSISSIPPI

DUBARD SCHOOL FOR LANGUAGE DISORDERS
SCHOOL OF SPEECH AND HEARING SCIENCES
118 College Drive #5215 | Hattiesburg, MS 39406-0001
Phone: 601.266.5223 | Fax: 601.266.6763 | www.usm.edu/dubard

Date: August 5, 2020

Dear Parents and Guardians,

As the Social Worker at the DuBard School for Language Disorders, my duties may address a wide range of activities. These include time in the classroom addressing needed social skills. It also includes meeting with individuals and families to address concerns involving not only the children but the family as a whole. As we all are aware, everything that happens in the family unit, both good and not so good, affects the children. If you just have a need to talk, I welcome the opportunity to listen!

I am a part-time employee, and my work schedule varies. Please feel free to call to make an appointment with me if I may be of assistance to you or your child. I may be reached at 601.266.5650. I am excited to be at the DuBard School and truly look forward to getting to know you and your child.

The DuBard School for Language Disorders requests your permission for your child to meet with the social worker on an as needed basis. This meeting will come about as a referral from his or her teacher (or from you or your child). All information obtained in these meetings is confidential and will not be discussed outside of the DuBard School without your permission. If you have questions, please call me. If I am not in my office at the time of your call, please leave a message on my voice mail, and I will return your call when I am back in the office. I look forward to working with you and your child.

Sincerely,

Cherice Nobles, LSW (DuBard School Social Worker)

Child's Name

I will allow my child to meet with the social worker choices:

- ○ **Yes, you may speak to my child.**
- ○ **Call me before speaking to my child.**
- ○ **No, you may not speak to my child.**

Parent or Guardian Name

07/27/2020

Date

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