

SUNMAN-DEARBORN MIDDLE SCHOOL
TROJANS

PHONE: 812-576-3500

8356 SCHUMAN RD.
ST. LEON, IN 47012

FAX: 812-576-3506

TO: (Name and Address of the School Last Attended)

The following student(s) have recently enrolled in our school. Please send a transcript or grades, health and immunization records, test scores and any other records which are available.

STUDENT

GRADE LAST ATTENDED

_____	_____
_____	_____

Thank you for your cooperation.

Sincerely,
Becky Hoog
Administrative Assistant/ Guidance

AUTHORIZATION FOR RELEASE OF RECORDS

PLEASE CHECK RECORDS TO BE SENT:

I hereby authorize the release of all records:

___scholastic ___health ___psychological ___standardized test results

___special education ___504 and other related material which may be of assistance in the proper placement and education of the student(s) named above.

Please forward to: **SUNMAN-DEARBORN MIDDLE SCHOOL**
8356 SCHUMAN RD ST. LEON, IN. 47012

Date

Signature of Parent or Guardian

Home Phone _____

Work Phone _____

Current Address

Father

Mother

SUNMAN-DEARBORN SCHOOL DISTRICT

I, _____, give the Sunman-Dearborn School District, permission to release the following information concerning my child _____ to the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):
Including Name, Immunization Data and Other Information Such as Date of Birth or Other Identifying Information as Applicable.

I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me or my child of my child's immunization status or that an immunization is due according to recommended immunization schedules.

I understand that my child's information may be available to the immunization data registry of another state, a healthcare provider or a provider's designee, a local health department, and elementary or secondary school, a child care center, the office of Medicaid policy and planning or a contractor of the office of Medicaid policy and planning, a licensed child placing agency, and a college or university. I also understand that the other entities may be added to this list through amendment to I.C.16-38-5-3.

I hereby consent to the release of such information.

Signature

Date

Printed Name of Parent or Guardian

Address

Telephone Number

Child's Name

Grade Level

School

Collecting Racial and Ethnic Data

Date: _____

As of 2009 - 2010 school year the Indiana Department of Education has changed how school corporations are to collect racial/ethnic data. This form is to be filled out for each student attending Indiana schools. Once this form is filled out it will be placed in the student's permanent record. This form is also to be filled out by each staff member

Please read the questions below and check the box that applies.

Name: _____

Race and Ethnicity: Both Part 1 and Part 2 of the question **MUST BE** answered.

Part 1: Ethnicity	Is this individual Hispanic/Latino (Choose only one) <input type="checkbox"/> No, not Hispanic/Latino <input type="checkbox"/> Yes, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American or other Spanish culture or origin, regardless of race.
Part 2: Race	What is the individual's race? (Choose one or more) <input type="checkbox"/> American Indian or Alaska Native: A person having origins any of the original peoples of North America and maintaining cultural identification through tribal affiliation or community recognition. <input type="checkbox"/> Asian: A person having origins in any of the original people of the far East, Southeast Asia, or in the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. <input type="checkbox"/> Black or African American: a person having origins in any of the black racial groups of Africa. <input type="checkbox"/> Native Hawaiian or Other Pacific Islander: a person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands. <input type="checkbox"/> White: A person having origins in any of the original people of Europe, The Middle East, or North Africa.

**CHECK HERE IF
INFORMATION HAS
CHANGED SINCE
LAST YEAR _____**

**SUNMAN-DEARBORN COMMUNITY SCHOOLS
STUDENT AND HEALTH INFORMATION
2017-2018**

MEDICAL ALERTS

(office use only)

Student: _____
(Last Name) (First Name) (Middle Name) M/F Age Date of Birth Grade

Mailing Address: _____
(Street/ PO Box) (City) (Zip Code)

(If you have a P.O. Box, list your 9-1-1 Address) _____

County: _____ Social Security #: _____ - _____ - _____ PARENT Email Address: _____

Home Phone: _____ Preferred weather related number _____

Preferred number for emergency/disaster _____ early dismissal _____

Student rides Bus # _____ AM (Circle) From: Home Daycare or Sitter Drives Other _____

Student rides Bus # _____ PM (Circle) To: Home Daycare or Sitter Drives Other _____

Race (circle): Asian or Pacific Islander Black White Hispanic American Indian Multiracial

Is parent(s)/guardian(s) currently active military personnel? ___ No ___ Yes

Student Lives With (circle): Mother StepMother Other (relationship) _____

Name: _____ Employer: _____ Shift: _____

Work Phone: _____ Cell: _____ Pager: _____

Student Lives With (circle): Father StepFather Other (relationship) _____

Name: _____ Employer: _____ Shift: _____

Work Phone: _____ Cell: _____ Pager: _____

If student does not live with both parents, are there custodial restrictions on non-custodial parent that the school should be aware of? YES ___ NO ___

Who has custody? _____ (custody papers are *required on file*)

Explain (or see Principal/Asst. Principal) _____

Name of Non-Custodial Parent: _____ Phone: _____

If the parent WITH custody cannot be reached in an emergency, can the school contact the parent *WITHOUT* custody? Yes ___ No ___

Can the parent *WITHOUT* custody pick-up the student from school? Yes ___ No ___

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached.

Name: _____ Phone: _____ Cell: _____

Name: _____ Phone: _____ Cell: _____

List siblings enrolled in this school corporation below:

Name: _____ School: _____

Name: _____ School: _____

Signature of Parent/Guardian: _____ **Date:** _____

Continued on the Back

Medical History and Consents:

The information on this form can be shared with other corporation personnel as necessary for the well being of this student. Consents granted on this form are valid for only this school year and a new form is required each year.

Parent Signature: _____ Date: _____

PLEASE CIRCLE AND FILL IN THE BLANKS TO ALL THAT APPLY BELOW:

ADD/ADHD Medication: _____ Dose: _____ Times Given: _____

Severe Allergic Reaction (Requiring Epi-pen & MD orders): TO WHAT? _____

Mild or Moderate Allergic Reaction: TO WHAT? _____

Is student allergic to any medications?: WHAT MEDICATION? _____

Seasonal Allergies: TO WHAT? _____

Severe Asthma (requiring inhaler/nebulizer & MD orders). List Inhaler/nebulizer used _____

Mild Asthma (no inhaler needed)

Diabetes (insulin dependent requires MD orders): Pump: Yes No Needs: (Circle) Insulin AM/PM Snacks

Epilepsy (Seizures): (Circle) Absence Tonic/Clonic Partial Date last seizure _____

Seizure Medications: _____

Hearing Loss: (Circle) Right Left Hearing Aid Needs Preferred Seating

Heart Condition: Specify _____

Headaches: (Circle) Frequent MD Diagnosed Migraines (needs MD orders)

Irritable Bowel: Explain _____

Menstrual Problems: Explain _____

Orthopedic Limits: Explain _____ PE limits _____

Restricted Physical Activities: _____

Psychological DX: _____

Scoliosis: _____

Urinary Problems: _____

Vision: (Circle) Glasses Contacts Other

Other: _____

List all prescription medications this student is currently taking: _____

Regulations established by the Indiana State Board of Health require that schools have parental permission to administer generic Tylenol, antacids, sore throat lozenges, Orajel, Aloe and Calamine Lotion for minor discomfort on an infrequent basis. (Ibuprofen is not stocked)

I hereby give permission for _____ to receive generic Tylenol, etc. during school hours
(Student Name)

Tylenol dosage given will be as follows: Two 325 mg tablets 12 years and older

Signature of Parent/Guardian: _____ Date: _____

In case of an accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician below and to follow his instructions and/or call the life squad. **Depending on the emergency the life squad will make the decision of where to transport your child according to their mandates.** If you would like to request a hospital, please circle one of the following. Margaret Mary Dearborn Co. Franciscan Med Center (Harrison)

Physician's Name: _____ Phone: _____

(Number must be provided)

Dentist's Name: _____ Phone: _____

PLEASE NOTIFY SCHOOL IF ANY OF THE ABOVE INFORMATION CHANGES

Emergency Notification Information

School year 2017-2018

Student Name _____

Birth Date _____

School Location SUNMAN-DEARBORN MIDDLE SCHOOL

Please return this form to the Guidance Office.

Please choose 1 phone number to call in the event of a snow closure or snow delay.

Weather related school closure / 2 hour delay number

Please include area code

Please choose 1 phone number to call in the event of an Early Dismissal.

Early Dismissal phone number

Please include area code

Please choose 1 phone number to call in the event of any type of disaster, (bomb threat, guns on premises, gas leak, no water, etc.).

Disaster phone number

Please include area code

Please choose 1 email address for notification. Please print legibly and somehow note if a 0 is a zero or the letter o, if a 1 is the number one or the letter L (lower case), etc.

Parent email

Please return form. Remember, if this form is not returned, you will not be notified. This form may be updated at the beginning of each school year.

Parent Signature _____

Date _____

SUNMAN-DEARBORN MIDDLE SCHOOL

Media Release Permission

Family Educational Rights and Privacy Act (FERPA)

Through the course of the school year, your child's photograph may be taken for various group and individual recognition. The photographs may be posted on the school or corporation website and/or may be distributed to local media sources and press releases authorized by the school or corporation.

Student FULL Name (Print): _____

Grade: _____

Please check ONE of the choices below:

_____ **I PERMIT** the use of my child's photo in school related media releases.

_____ **I DO NOT PERMIT** the use of my child's photo in school related media releases.

Parent Signature

Date

The Family Educational Rights and Privacy Act (FERPA) requires that SDMS obtain your written consent prior to the disclosure of personally identifiable information/pictures from your child's record. Your signature above grants SDMS permission or denial of permission for this information to be disclosed. **THIS INCLUDES YEARBOOK PHOTO, SPORTS PICTURES, NEWSPAPER ARTICLES, CLUB PHOTOS, ETC!!!**

The Migrant Education Program (MEP) provides supplemental education and support services to eligible children through national funding. The purpose of the program is to ensure that all migrant students reach the academic standards and graduate with a high school diploma (or complete GED/HSE).


WORK SURVEY

Thank you for answering the following questions. If your child is eligible for the Migrant Education Program, they may receive additional educational support. This information is **strictly confidential**.

Student's Name: _____ Parent's Name: _____

Address: _____ City: _____ Telephone: (____) _____

Date: _____ Parent Signature: _____

1. How long have you lived in this city/school district? _____
2. Within the last **3 years**, has your child(ren) moved from one school district to another within the United States, with a parent, relative or guardian so that person could look for seasonal or temporary work in agriculture? **YES** ___ **NO** ___ If you answered **NO**, please stop. 

If you answered **YES**, please continue.

3. When was the last time you or anyone in your household has moved to look for, or work in an agricultural activity within the United States? Month _____ Year _____
4. Please check any of the agricultural activities listed below that you have looked for or worked in:

- | | |
|---|---|
| <input type="checkbox"/> Plant or harvest vegetables or fruits | <input type="checkbox"/> Canning vegetables or fruits |
| <input type="checkbox"/> Detassel corn | <input type="checkbox"/> Sod farm |
| <input type="checkbox"/> Tobacco farm | <input type="checkbox"/> Planting, pruning or cutting trees |
| <input type="checkbox"/> Poultry and/or egg farm | <input type="checkbox"/> Dairy farm |
| <input type="checkbox"/> Duck, turkey, chicken, pork or beef processing plant | <input type="checkbox"/> Flora culture/gladiola farm |
| <input type="checkbox"/> Aquaculture/fish hatcheries | <input type="checkbox"/> Green house or plant nursery |

Please list the names of all of the children in the household under 22 years of age.

Child's Name	Date of Birth (D.O.B.)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

El Programa de Educación Migrante (MEP) provee servicios educativos suplementarios a niños que califican a través de fondos nacionales. El propósito del MEP es asegurar que todos los estudiantes migrantes tengan éxito académico y que se gradúen con su diploma (o que completen el GED/HSE).

ENCUESTA DE TRABAJO

Gracias por contestar las siguientes preguntas. Si su hijo/a es elegible para el Programa de Educación Migrante, podría recibir apoyo educativo adicional. La información es **completamente confidencial**.

Nombre del Estudiante: _____ Nombres de los Padres: _____

Dirección: _____ Ciudad: _____ Teléfono: (____) _____

Fecha: _____ Firma de los Padres: _____

1. ¿Cuanto tiempo han vivido en esta ciudad/distrito escolar? _____
2. Durante los **últimos 3 años**, ¿Se ha mudado su(s) hijo(s) o han cambiado de distrito escolar dentro de los Estados Unidos, solo(s), o con un padre o pariente, para que esa persona pudiera buscar trabajo temporal o de temporada en algo relacionado con la agricultura?

SI _____ **NO** _____ Si contestó **NO**, favor de parar aquí. 

SI contestó **SÍ**, favor de continuar.

3. ¿Cuando fue la última vez que usted o un miembro de su familia se mudó para trabajar en la agricultura? Mes _____ Año _____

4. Por favor marque en la parte abajo la actividad agrícola en que usted buscó trabajo o trabajó.

- | | |
|---|--|
| <input type="checkbox"/> Matadero de patos, pavos, pollos, cerdos o vacas | <input type="checkbox"/> Enlatar o congelar verduras o frutas en la bodega |
| <input type="checkbox"/> La espiga (maíz) | <input type="checkbox"/> Trabajar en la siembra o cosecha de césped |
| <input type="checkbox"/> Cultivar tabaco | <input type="checkbox"/> Plantar, emparejar o cortar árboles |
| <input type="checkbox"/> Pollería o granja de huevos | <input type="checkbox"/> Granja de vacas lecheras |
| <input type="checkbox"/> Plantar o cosechar verduras o frutas | <input type="checkbox"/> Cultivar y cosechar flores |
| <input type="checkbox"/> Trabajar en un criadero de peces | <input type="checkbox"/> Trabajar en la cría de plantas |

Por favor escribe los nombres de todos los niños, menores de 22 años de edad, que viven con usted.

Nombre del niño(a)	Fecha de nacimiento
1.	
2.	
3.	
4.	
5.	

YEARBOOK ORDER FORM

Order your 70 page hard back yearbook today!

Cost is \$25.00

Order forms need to be completed and turned in with money attached in an envelope to the front office.

Deadline to order yearbooks at this price is October 5th.

Student Name _____

Grade _____

Advisory Teacher _____

Quantity Ordered _____ Cash _____ Check # _____

Please make checks payable to:

Sunman Dearborn Middle School



Library Card Application

Legal Name: (Please Print)

Last _____ First _____ MI _____

Current Physical Address:
Address _____

City _____ State _____ Zip _____

Township _____ Home /Cell Phone# _____ Work Phone# _____

Alternate Address or PO Box _____

Email Address (notification purpose) _____ Social Security Number _____

Birth date _____ Age (if under 18) _____ Parent/Guardian Name (if under 18) _____

Would you be interested in receiving the Monthly Library Newsletter via email? Yes _____
Would you like your online READING HISTORY activated? Yes _____

By signing below, I agree to obey all the rules and regulations of the library, to pay promptly all fines & fees charged against me for the damage or loss of library items, and to give immediate notice of any change of address.

Applicant's Signature _____

Parent's Signature (if under 14) _____

Date _____

For Library Use :

Resident of Dearborn Co.

Indiana Reciprocal Borrower

PLAC

Paid Non-Resident

Educational

Boone County Reciprocal

FOR LIBRARY USE ONLY

Reciprocal Borrower Home Library: _____

PLAC # _____ Ex Date: _____

PLAC Home Library: _____

Notes: _____

Staff Initials: _____