TEXAS HEARING INSTITUTE

Melinda Webb School

Enrollment Packet – English

2023-2024

It is the Parent/Guardian's responsibility to update phone numbers, employment information and other pertinent information throughout the year.

3100 Shenandoah St., Houston, TX 77021 TEL | 713.523.3633 FAX | 713.523.8399 | www.texashearing.org

United Way of Greater Houston

THE MELINDA WEBB SCHOOL

Registration Agreement

* Each student will be required to pay a non-refundable registration fee of $100. This fee will be due annually upon receipt of the registration agreement

Student's Name: _____

I wish to enroll, my child for the 2023-2024 Academic School Year.

Please select all enrollment options that apply:

☐ Melinda Webb School full day program, Monday to Friday from 8 AM – 3 PM

☐ Melinda Webb School part-time LEAP program, two days a week from 8am - 12pm (only if you qualified)

☐ Morning Care "Rise & Shine" from 7 AM – 8 AM at an additional cost

☐ After Care "Later Gator" from 3 PM – 6 PM at an additional cost

☐ Early Learning Year-Round Program, Monday to Friday from 7 AM – 6 PM

☐ I wish to apply for Financial Aid for the 2023-2024 school year. I understand that I must provide all required financial documents.

2023 Summer Program:

☐ I am interested in the 2023 Summer Program (6/7/23 – 8/4/23) ($300/week)

☐ I am interested in Drop-In Care ($330/week)

Please add the dates below:

THE MELINDA WEBB SCHOOL

STUDENT INFORMATION

Student's Name: _____ DOB: _____

Race (optional): ☐ African American ☐ Asian ☐ Caucasian ☐ Other: _____

Ethnicity (optional): ☐ Hispanic ☐ Non-Hispanic Gender: ☐ Male ☐ Female

Language spoken at home: _____ Parent's Preferred Language: _____

Address: _____
Street Apt #

_____
City State Zip Code Zoned school district County

Student lives with: ☐ Mother ☐ Father ☐ Both ☐ Other: _____

Is your child receiving any special services?

- ☐ Speech Therapy Location: _____
- ☐ Audiology Location: _____
- ☐ Physical/ Occupational Therapy Location: _____
- ☐ Other: _____ Location: _____

Parent 1 Name: _____ Cell phone: _____

Email: _____ Work phone: _____

Employer: _____ Highest level of education: _____

Home Address: _____ Does this parent have hearing loss? ☐ Yes ☐ No

^ For Address please write "same as student" if applicable

Parent 2 Name: _____ Cell phone: _____

Email: _____ Work phone: _____

Employer: _____ Highest level of education: _____

Home Address: _____ Does this parent have hearing loss? ☐ Yes ☐ No

^ For Address please write "same as student" if applicable

Other Parent/Guardian: _____ Cell phone: _____

Email Address: _____ Relationship to child: _____

Is there anything else we should know about your child (ie. Medical information, behavioral information, etc.):

_____

THE MELINDA WEBB SCHOOL

PARENT INVOLVEMENT

Student's Name: _____

PTO (Parent – Teacher Organization)

PTO is the Parent – Teacher Organization that helps support the staff and students at MWS.

☐ I am interested in receiving emails about and from PTO

School Emails

Please check off which Parents should be included in school emails:

☐ Parent 1 (required)
☐ Parent 2
☐ Other Parent/ Guardian

School Directory

This is a way for you to connect with other parents in MWS.
Please initial what you are comfortable with:

☐ Yes, I would like to receive and provide my information to other parents in the school
☐ Yes, I would like to receive and provide my information ONLY to the other parents in my child's class
☐ No, I do not wish to receive or provide my information to other parents

If yes, please check all the information that you are comfortable sharing with other MWS parents:

☐ Child's Birthday
☐ Parent 1 Email
☐ Parent 1 Phone Number
☐ Parent 2 Email
☐ Parent 2 Phone Number
☐ Family Address

The School Directory is intended for the use only by school staff and parents of Melinda Webb School. The names, addresses and telephone numbers of parents and staff listed in this Directory may not be given out by anyone for use in commercial mailing lists, business solicitations, or for any purposes not pertinent to the activities of MWS. We appreciate your cooperation in protecting the privacy of the children, the parents and the staff.

Parent Support Groups

THI facilitates family support groups, in both Spanish and English, for all THI families.

☐ I am interested in receiving information on upcoming support groups

Parent Connect Group

This is a way to connect new MWS parents with current MWS parents. If you are able to connect and share your experience with new parents, please sign up below.

☐ I am interested in participating in the parent connect group to connect with new enrolling MWS parents
☐ I am a new MWS parent and I am interested in connecting with current MWS parents

THE MELINDA WEBB SCHOOL

ALLERGY ALERT/FOOD RESTRICTION NOTICE

Student's Name: _____

Dietary Restrictions:

Does your child have any dietary restrictions? ☐ Yes ☐ No

If *Yes*, please list: _____

Allergies

Does your child have any **food** allergies? ☐ Yes ☐ No

If *Yes*, please list food item(s) as well as **type** and **severity** of reaction:

Food Item:	Type/ Severity of reaction:
_____	_____
_____	_____
_____	_____

If your child experiences the reaction listed to the allergens above, please note the action you would like the teacher to follow *(ex: inject epinephrine, apply ointment, call 911)*:

_____

Does your child's allergies require an emergency action plan from you physician? ☐ Yes ☐ No

If yes, please provide.

Does your child have any **other** allergies? ☐ Yes ☐ No

If *Yes*, please list item(s) as well as **type** and **severity** of reaction:

Item:	Type/ Severity of reaction:
_____	_____
_____	_____

If your child experiences the reaction listed to the allergens above, please note the action you would like the teacher to follow *(ex: inject epinephrine, apply ointment, call 911)*:

_____

Does your child's allergies require an emergency action plan from you physician? ☐ Yes ☐ No

If yes, please provide.

ALL MEDICATION NEEDED TO TREAT ALLERGIC REACTIONS MUST BE LISTED ON YOUR CHILD'S MEDICATION AUTHORIZATION FORM AND LEFT AT SCHOOL

_____	_____	_____
Parent's Name	Cell Phone	Date

THE MELINDA WEBB SCHOOL

STUDENT HEALTH INFORMATION & IMMUNIZATION RECORD & HEALTH REQUIREMENT

Student's name _____

Medical insurance carrier: _____ Policy number: _____

Pediatrician/PCP: _____ Doctor's phone: _____

STUDENT HEALTH INFORMATION

List all the surgeries that your child has had in the last 12 months: _____

List all the medications your child takes on an ongoing basis: _____

Does your child take these medications during school hours? ☐ Yes ☐ No

IF YOUR CHILD REQUIRES SPECIALIZED MEDICAL ASSISTANCE, YOU MUST PROVIDE A COPY OF HEALTH CARE PROVIDER'S RECOMMENDATIONS AND SUBMIT A MEDICATION ADMINISTRATION FORM LOCATED AT THE SCHOOL FRONT DESK

Please attach a copy of your child's most current immunization record.

☐ I have provided the childcare operation with a copy of my child's most current immunization record.

☐ I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.

*Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about (date) _____ and does not need varicella vaccine.

ADMISSION REQUIREMENT: If your child does not attend pre-kindergarten or school away from the child-care operation, one of the following must be presented when your child is admitted to the child-care operation or within one week of admission.

Please check only one option:

☐ 1. HEALTH-CARE PROFESSIONAL'S STATEMENT: I have examined the above-named child within the past year and find that he / she is able to take part in the day care program.

Health Care Professional's Signature: _____ Date: _____

☐ 2. A signed and dated copy of a health care professional's statement is attached. (A copy of their most recent well-child report may be used)

☐ 3. Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.

☐ 4. My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and will submit it to the child-care operation.

Name and address of health care professional:

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CONSENTS

Student's name _____

Please INITIAL on all that you consent to and write "NO" for what you do NOT consent to:

Water activities:

___ I hereby give my consent for my child to participate in water activities such as splash pools, wading pools, sprinkler play, water table play and/or other bodies of water provided by the facility.

Recreational equipment and activities

___ I hereby give my consent for my child to use all learning and recreational materials and indoor and outdoor equipment connected with the daily program.

Food provided by the Melinda Webb School (MWS):

___ I hereby give my consent for my child to eat special snacks and food provided during activities at MWS. MWS only offers pre-packaged snacks and shelf-stable foods.

Transportation:

___ I hereby consent for my child to be transported and supervised by the operation's employees for field trips.

Field Trips:

___ I hereby consent for my child to participate in field trips.

Screenings:

___ I understand that the Melinda Webb School is required to screen hearing and vision on all students who are 4 + years old annually. A full developmental screening of physical, cognitive, social-emotional, and adaptive skills is completed on each student annually. Referrals for in depth assessments may be made based on screening results of any of the above areas of development.

Receipt of Privacy Policy & Written Operational Policies:

___ I acknowledge receipt of the Privacy Policy and Facility's operational policies including those for discipline and guidance.

Pick-Up Authorization:

Parents are required to add all approved pick-up persons to their child's Brightwheel account. Students can only be released from the childcare operation to a person listed on the student's Brightwheel account AND after verification of the pick-up person's ID. If an individual is not listed as an approved pick-up for a student, they will not be authorized to leave the childcare operation with the student.

____ I hereby authorize the childcare operation to allow my child to leave the childcare operation ONLY with the persons listed in my child's Brightwheel profile.

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EMERGENCY CONTACT

Student's Name: _____ Parent Name: _____

Please list two individuals to be contacted if parents cannot be reached in an emergency:

Name: _____ Relationship: _____

Phone number(s):_____ Address: _____
Is this person authorized to pick-up your child from school? ☐ Yes ☐ No

Name: _____ Relationship: _____

Phone number(s):_____ Address: _____
Is this person authorized to pick-up your child from school? ☐ Yes ☐ No

Are there any particular individuals who may **not** pick up your child? ☐ Yes ☐ No

If so, Name: _____ Reason*: _____

* You may be required to provide legal documentation

EMERGENCY AUTHORIZATION

I hereby authorize *Texas Hearing Institute* to take _____
(Child's Name)
to the nearest facility to be treated by licensed physician or medical personnel in case of emergency.

By signing I am affirming that all the information in this packet is correct and complete.

Parent/Guardian signature: _____ Date: _____