STUDENT INFORMATION SHEET

TO BE FILLED OUT BY THE **PARENT** - PLEASE FILL OUT **COMPLETELY** AND RETURN TO SCHOOL BY THE FIRST THURSDAY

STUDENT'S **FULL** NAME _____ DOB_____

NAME STUDENT GOES BY _____ CURRENT GRADE_____

PARENT'S/GUARDIAN'S NAME(S)_____

MAILING ADDRESS _____

CITY _____ ST _____ ZIP _____ HOME PHONE (____)_____

911 ADDRESS (IF DIFFERENT FROM MAILING ADDRESS)_____

FATHER'S EMPLOYER _____PHONE_____

MOTHER'S EMPLOYER _____PHONE_____

STUDENT CELL (____)_____ MOM CELL(____)_____ DAD CELL (____)_____

FAMILY PHYSICIAN _____ PHONE _____

EMERGENCY CONTACT OTHER THAN PARENT_____

RELATIONSHIP_____ PHONE _____ 2ND PHONE _____

STUDENT EMAIL _____ (necessary for 6th grade and up)

MOM'S EMAIL _____DAD'S EMAIL_____

CHILD LIVES WITH (circle one): MOM, DAD, BOTH PARENTS, OTHER_____

CHILD MAY BE PICKED UP BY: _____

RELIGIOUS/CHURCH PREFERENCE_____

ALLERGY/MEDICAL INFORMATION:_____

BROTHER(S)/SISTER(S) NAME(S) & AGE(S)_____

DID PARENT/STEP-PARENT GRADUATE FROM DESOTO? _____ NAME and GRAD. YEAR_____

DID GRANDPARENT GRADUATE FROM DESOTO? _____ NAME AND GRAD. YEAR _____

Any other pertinent information school should be aware of: (e.g. custody, medical history, etc.)

_____

_____ _____

Parent Signature Date

JupiterEd requires internet access. Check here if you do not have internet and will need printed reports. _____

DeSoto School, Inc.
P.O. Box 2807
West Helena, AR 72390

HANDBOOK FORM

This serves notice that I have read the online copy of the 2026-2027 DeSoto School, Inc., Student Handbook. I understand that I am responsible to be aware of all policies, rules and regulations set forth by the Board and Administration of DeSoto School, Inc.

THIS FORM IS TO BE SIGNED AND GIVEN TO THE HOMEROOM TEACHER BY THURSDAY, AUGUST 6, 2026, OR THE STUDENT WILL BE ASSIGNED TWO (2) DEMERITS. IF NOT RETURNED BY HOMEROOM ON FRIDAY, AUGUST 7, 2026, THE STUDENT WILL RECEIVE FIVE (5) ADDITIONAL DEMERITS.
A SEPARATE FORM MUST BE SUBMITTED FOR EACH STUDENT.

All students must be current on immunizations and submit written proof of updated immunizations or an exemption.

Student Name: _____ Grade: _____

Student's Signature _____

Parent Signature _____

Date: _____

Please be advised that during the school year, your child may be photographed, videoed, or interviewed at various school sponsored events. With your consent, the photographs, videos, etc. may be released for promotion of DeSoto School in the newspaper, brochures, the school website, and other school related social media platforms such as Facebook, Instagram, etc.

Please indicate your preference below.

Student's Name:_____
Grade:_____

(Check one)

☐ Yes, my child's photos/videos may be released for use in the media as described above.

☐ No, my child's photos/videos may NOT be released for use in the media as described above.

This form must be returned to school with handbook receipt form!!!!

Student's Name: _____ DOB_____ Grade: _____

Address: _____ City: _____State: _____ Zip:_____

Father's Name: _____ Phone: _____

Mother's Name: _____ Phone: _____

A. Authorization to Consent to Medical Treatment: In the event my child becomes ill or injured at school or in a school related event and I cannot be reached, DeSoto School, Inc. of West Helena, AR is authorized to take one or more of the following actions: (a) release my child to either of the people listed below; (b) take my child to the physician indicated; (c) take my child to a hospital and give consent for emergency care.

Local emergency telephone number if parents cannot be reached:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

B. Release and Authorization to Participate in Athletic, Physical Education and School Trips: I give my consent for my child to participate in all DeSoto School's approved sports; extra curricular activities and school trips with transportation being provided by the school, coach, or other representative of the school.

I understand that by participating in physical education and athletics at DeSoto School, Inc. my child will be exposed to the risk of injury. I understand that contact sports such as football, basketball, track, softball and baseball do have a risk factor of injury

I understand that DeSoto School, Inc. does not assume any responsibility in case an accident occurs. In consideration for my child being permitted to take part in such activities, and to make such trips, I hereby waive all claims, and I release DeSoto School, Inc. from any liability claims, suits, demands or causes of action, including all expenses.

C. Authorization of Administration of Medication at School: I give my consent for my child to be administered the following non-prescription medication(s) by school officials:
Tylenol _____ Ibuprofen _____ Anti-Itch Cream _____ Benadryl Liquid _____
Neosporin _____ Pepto Bismol _____ Bactine_____ Sunscreen_____

Other medications which may be required by the student during school hours or activities must be supplied by the parents and brought to the school in the original container properly labeled with the name of the student and identification of the medication, the dosage, and the time to be administered by the teacher.

_____ _____

Signature of Parent Date

DESOTO AFTER-SCHOOL CARE

TIME: 3:05 PM UNTIL 5:30 PM MONDAY – FRIDAY
(Except on announced ½ days)

COST $150 per month (August through May) added into monthly tuition payments. (This is for full-time care commitments.)
This year we are offering after-school care for drop-ins at the rate of $12.50/hour (billed at the end of each month.)

LATE FEE: $1.00 PER MINUTE WILL BE ASSESSED FOR STUDENTS NOT PICKED UP BY 5:30. Frequent lateness will result in the child not being allowed to attend.

ELIGIBLE: DESOTO STUDENTS GRADES K3 THROUGH 6TH GRADE.

PARENTS SHOULD CHECK BELOW IF THE CHILD WILL BE FULL-TIME OR POSSIBLE DROP-IN. (PARENTS WILL NEED TO NOTIFY THE HOMEROOM TEACHER EACH DAY THAT A DROP-IN WILL STAY AFTER SCHOOL.)

SNACKS: PLEASE SEND AN AFTERNOON SNACK WITH YOUR CHILD. MILK WILL BE PROVIDED.

CHILD'S NAME: _____

My child will be full-time_____ **My child will be a possible drop-in**_____

PARENT'S NAME: _____

CELL PHONE: _____

EMERGENCY CONTACTS: _____

My child may be picked up by : _____

_____

Allergy Information

Student Name _____

Grade_____

_____My child has no known allergies.

_____My child is allergic to the following:

_____

_____

_____

Grandparent Information Form

Student Name_____

Grade_____

Grandparent Name_____

Address_____

City, State, Zip_____

Grandparent Name_____

Address_____

City, State, Zip_____

Grandparent Name_____

Address_____

City, State, Zip_____

Grandparent Name_____

Address_____

City, State, Zip_____

Grandparent Name_____

Address_____

City, State, Zip_____

DeSoto School, Inc.
Parent Permission/Consent for Participation in Sports (4th – 12th grades)

Printed Name of Student _____ Grade_____

This application to compete in interscholastic athletics is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the MAIS.

Signature of Student_____ Date_____

Parent or Guardian's Permission and Release:

I hereby give my consent for the above-named student to represent DeSoto School in athletic activities. I certify that he/she is physically fit to participate according to our family physician.

The School Board and its administration/coaches have no responsibility to provide first aid at any of the games, and the parent or guardian understands that the risk of injury is assumed by the student and the parent when they sign this form. However, if physicians, physical therapists, nurses, or other persons trained in the rendering of first aid are available (as volunteers or otherwise) and render aid to any student injured during the course of any activities, then the parents do hereby release and forever discharge such persons and the DeSoto School Board and its administration/coaches from any liability arising out of any first aid or immediate treatment of injuries.

I understand that DeSoto does not maintain a supplemental policy of insurance on my child for sports-related injuries. I acknowledge that my child is covered by medical insurance as listed:

Insurance Co. _____ Policy Number_____

Check here if the student has NO medical insurance _____

Printed Name of Parent or Guardian _____

Signature of Parent or Guardian _____

Phone _____

Date _____

Please check the sports in which the student will participate:

_____Football	_____Cross Country	_____Baseball	_____Golf
_____Softball	_____Basketball	_____Tennis	
_____Cheer	_____Track	_____Other (if offered)	

Health Form for Athletes

(Complete for each student in 6-9th grades and athletes in 4-5th grades and 10-12th grades)

Student Name_____Grade_____

Parent/Guardian Name_____

Family Doctor Name_____ Doctor's Phone _____

Any medical information concerning the student that we should know? (asthma, allergies, etc.)

_____

_____

Check all that apply to the student:

_____Chronic or recurrent illness

_____Hospitalizations

_____Surgery other than tonsillectomy

_____Missing organs

_____Allergy to any medication

_____Problems with heart or blood pressure

_____Chest pain with exercise

_____Dizziness or fainting with exercise

_____Dizziness, fatigue, headaches, convulsions

_____Concussions or unconsciousness

_____Heat exhaustion, heatstroke, problems with heat

_____Injuries requiring medical treatment

_____Neck or back injury

_____Knee injury

_____Ankle injury

_____Broken bones, fractures

_____Eye glasses or contacts

_____Braces, dental bridges, dental plates

_____Takes any medication

_____Had a family member die suddenly at less than 40 years of age of causes other than an accident

_____Had a family member suffer a heart attack at less than 55 years of age

USE THE SPACE TO THE RIGHT OF ANY CHECKED ANSWERS TO EXPLAIN OR PROVIDE ADDITIONAL INFORMATION.

MAIS Concussion Policy & Verification:

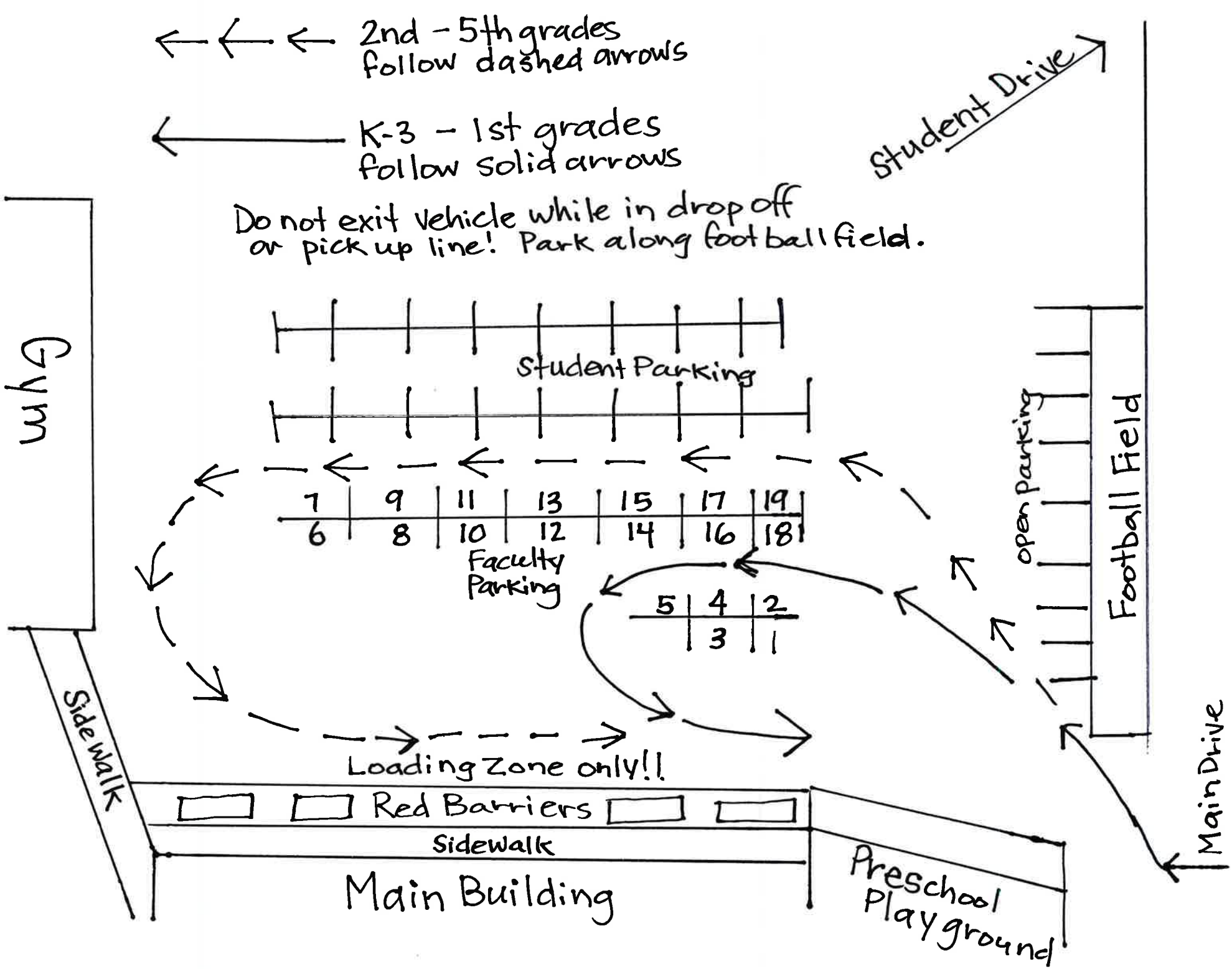
- An athlete who reports or displays any symptoms or signs of a concussion in a practice or game setting should be removed immediately from the practice or game. The athlete should not be allowed to return to the practice or game for the remainder of the day regardless of whether the athlete appears or states that he/she is normal.
- The athlete should be evaluated by a licensed, qualified medical professional working within their scope of practice as soon as can be practically arranged.
- If an athlete has sustained a concussion, the athlete should be referred to a licensed physician preferably one with experience in managing sports concussion injuries.
- The athlete who has been diagnosed with a concussion should be returned to play only after full recovery and clearance by a physician. Recovery from a concussion, regardless of loss on consciousness, usually takes 7-14 days after resolution of all symptoms.
- Return to play after a concussion should be gradual and follow a progressive return to competition. An athlete should not return to a competitive game before demonstrating that he/she has no symptoms in a fully supervised practice.
- Athletes should not continue to practice or return to play while still having symptoms of a concussion. Sustaining an impact to the head while recovering from a concussion may cause Second Impact Syndrome, a catastrophic neurological brain injury.

Remember, it is better to miss one game than to miss the whole season!!!

I have reviewed this information on concussions and am aware that a release by a medical doctor is required before a student may return to play under this policy.

Student-Athlete Name Printed	Student-Athlete Signature	Month	Day	Year

Parent Name Printed	Parent Signature	Month	Day	Year


2nd - 5th grades
follow dashed arrows
K-3 - 1st grades
follow solid arrows
Student Drive
Do not exit vehicle while in drop off
or pick up line! Park along football field.
Gym
Student Parking
7 9 11 13 15 17 19
6 8 10 12 14 16 18
Faculty
Parking
5 4 2
3 1
open parking
Football Field
Sidewalk
Loading Zone only!!
Red Barriers
Sidewalk
Main Building
Preschool
Playground
Main Drive