CAPE MAY COUNTY TECHNICAL HIGH SCHOOL

188 CREST HAVEN ROAD, CAPE MAY COURT HOUSE, NJ 08210
(609) 380-0220
Fax: 465-4978
www.capemaytech.com

Application for Admission School Year 2018-19

High School (Full Day) _____ Career/Technical Only (Partial Day) _____ Date of Application ____/____/____

Please Print All Information

Student Name: _____
Last First Middle Initial

Primary Residence: _____
(For Transportation if mailing address is a Post Office Box) Number/Street City State Zip Code

Mailing Address: _____
Street/PO Box City State Zip Code

Telephone No. Home: ( ) _____ Gender: Female _____ Male _____

Student Date of Birth ____/____/____ Age _____ Birthplace: _____
City State

Present Grade: _____ School Presently Attending :_____

Address of School (If outside of Cape May County) _____
Number/Street

_____
City State Zip Code

Telephone No. (_____)_____ School Fax No. (___)_____
Area Code Area Code

Technical Program of Interest:
9th & 10th Grade: All students will be enrolled in the Exploratory Program (an overview of all careers offered below).

11th & 12th Grade: Indicate 1st, 2nd, and 3rd choices from list below.

___Advertising Design & Commercial Art
___Agriscience & Horticultural Technology
___ Allied Medical Technology
___ Automotive Mechanics Technology
___ Carpentry & Property Management
___ Communication Arts Technology
___ Computer Technology
___ Cosmetology
___ Culinary Arts
___Diesel/Small Engine Technology
___ Early Childhood Development
___Entertainment Production Technology
___Entrepreneurship
----Foods Production/ Commercial Foods
___HVAC-R/Sustainable Energy
___Law Enforcement & Public Safety
___Natural Science Technology
___Pastry/Baking Technology
___Pre-Engineering Technology
___Travel, Tourism, Event Planning & Marketing
___Welding Technology

Student Name:

_____
Last Name First Name Middle Initial

Race/Ethnicity: (Check all that apply. You are not required to answer this question.)
White _____ Black _____ Hispanic _____ Asian _____ Native Hawaiian/Pacific Islander _____ American Indian/Alaskan Native _____

Please list any special awards you have received: _____

Have you ever attended Cape May County Technical High School? Yes _____ No ____
(Activity Attended)

Have brothers/sisters ever attended this school? Yes ____ No ____ Names: _____

How did you learn about the Technical High School? □School Presentation □T.V. □Friends/Family □Teacher/Counselor □ Other_____

Co-Curricular Interests: (Please circle sports and/or activities of interest.)

Baseball	Swimming	Mock Trial	Peer Leadership
Basketball	Intramural Volleyball	National Honor Society	Student Government
Cheerleading	Fitness Training	Yearbook	Academic Competition Team
Cross Country	Aquaculture Club	Archery Club	Intramural Bowling
Golf	Girls Who Code Club	Robotics	School Based Youth
Soccer	FFA	Skills USA	Services (Activities & Clubs)
Softball	Spanish Club	Key Club International	

_____
Last Name First Name Home Phone Cell Phone
Father/Guardian (Circle One)

_____ _____
E-mail Work Phone

_____
Last Name First Name Home Phone Cell Phone
Mother/Guardian (Circle One)

_____ _____
E-mail Work Phone

I give my permission as parent/guardian to have academic transcripts or report cards, attendance records, standardized test scores, complete discipline log/ records, (if applicable) most recent IEP and/or 504 plan, and health records released to the Cape May County Technical High School Admissions Office.

_____ ____/_____/_____
Parent/Guardian Signature Date

My signature verifies that the information contained herein is true and correct. I realize that false or incomplete information can be cause for non-acceptance or dismissal.

SEND THE COMPLETED APPLICATION:

Admissions Coordinator, Cape May County Technical High School
188 Crest Haven Road
Cape May Court House, NJ 08210

DO NOT send the application to the school the applicant presently attends. You will receive acknowledgment indicating receipt of the application. If you have any questions, please call the Admissions Office at (609) 380-0220.

The Cape May County Technical School District ensures access to all schools, facilities, programs, activities, and benefits for all students, regardless of race, creed, color, national origin, ancestry, age, marital status, affectional or sexual orientation, gender, religion, disability or socioeconomic status.
9/20/17

Cape May County Technical High School **New Applicant Health Record for 2018-19**

Student Name:_____ D.O.B.___/___/___ Current School:_____ Grade:___

Check program applying for: □Full Day □Half-day (Name of other school your child will attend:_____)

Student's Physician:_____ Telephone:_____
Student's Dentist:_____ Telephone:_____

Does your child have Medical/Health Insurance? If Yes, name of insurance company:_____

If NO HEALTH INSURANCE sign indicating permission to release your name and address to New Jersey Family Care.
Signature: _____ Printed Name:_____ Date:____/____/____
Written consent required pursuant to 20U.S.C. & 1232g (b) (1) and 34 C.F.R. 99.30(b)

Check box of any health conditions your child has: *Only pertinent health information is shared with staff.*

□ Allergy to Medication(s): List medications allergic to_____
□ Latex allergy (medical gloves, tapes, etc):
If exposed to latex, does your child require emergency epinephrine medication? NO YES
□ Food allergy - List foods allergic to:_____
If exposed to food allergy, does your child require emergency epinephrine medication? NO YES
□ Insect allergy - List insects allergic to: _____
If stung/bitten by insect, does your child require emergency epinephrine injection? NO YES
□ Diabetes - Insulin dependent? NO YES Type of device used to administer insulin? □Syringe □ Pen □ Pump
□ Seizure Disorder: Type: _____ Date of last seizure: ___/___/___ Medication:_____
□ Asthma - Carries emergency relief inhaler in school? NO YES If "YES" Name inhaler: _____
□ Bleeding disorder: name/type of disorder:_____
□ ADHD: Medication:_____ Medication need to be administered during school hours? NO YES
□ Migraine headaches evaluated by a physician. Medication, or other treatment, taken: _____
□ Vision: □Glasses □Contacts □Nystagmus Blind in (circle which eye): Right Eye or Left Eye
□ Color deficiency (also known as being "color blind") – Type: □ RED/GREEN or □ other:_____
□ Hearing difficulty: which ear: ___Right ___Left ___Both Hearing aids worn? NO YES
□ Needs to have other adaptive devices (wheelchair, leg braces, etc): Indicate type: _____
□ Mental/emotional health diagnosis:_____ Share information with teachers? YES NO
□ Hospitalizations, surgeries, injuries or illnesses the **past 12 months**. Explain: _____
□ Other problem(s) not listed above. Explain: _____
□ Other medication(s) taken not listed above: _____

In the event of a medical emergency your child will be transported to the nearest hospital emergency room.
Indicate your contact information, and anyone else you want us to contact, in the event you cannot be reached.

#1 Parent/Guardian Name: _____ Home: _____ Work:_____ Cell:_____

#2 Contact Name: _____ Relationship: _____ Home: _____ Work:_____ Cell:_____

#3 Contact Name: _____ Relationship: _____ Home: _____ Work:_____ Cell:_____

Indicate name(s) of the parent(s) or guardian(s) child lives with: Name(s): _____

Address: _____
Street Town/City Zip code

Mailing address (if different from above):_____

I give permission for the nurse to administer as indicated and outlined by the school physician: (cross off any items you do not want your child to receive): OTCs: acetaminophen or ibuprofen, throat lozenges, topical antibiotic ointments and antiseptics, calamine lotion, hydrocortisone crème, oragel/ambesol/canker sore relief, blister care gel, burn relief (spray/ointment/Watergel)

Parent/guardian signature:_____ Date:_____

Attachment: Communication of Student Health Needs to Transportation Coordinator (Full Day High School student only) 9/2017

Cape May Technical High School
188 Crest Haven Road
Cape May Court House, New Jersey 08210
Admissions Office: (609) 380-0200 ext. 691

Communication of Student Health Needs to Transportation Coordinator

(Complete this page only if your child will be enrolled in the high school full day program and has a medical condition you want the bus driver to know about.)

Dear Parent/Guardian of Full Day student,
As transportation staff may change, or be substituted, it may be important for your child's bus driver to know of your child's medical condition and emergency contact information. This form will serve to communicate any special health concerns or treatments to your child's bus coordinator.
Return this form to the Admissions Office in person or postal mail.

********** Parent/Guardian completes the information below**********

Student's name (print):_____ D.O.B.____/____/_____ Grade:_____

□ Seizure Disorder List medications taken to control seizures, if any: _____
Type of seizure:_____ Aura if any:_____

□ Insulin Dependent Diabetic: Must have glucose source available (i.e. glucose gel, honey, cake icing)

□ Asthmatic needs to carry inhaler: Name of inhaler:_____ Dose:#___ inhalations taken

□ Life Threatening Allergy
My child needs to self-administer his/her prescribed auto-injector **epinephrine** if exposed to:

Food(s):_____ Insects/bees:_____ Latex:_____ Other: _____

□ Bleeding Disorder: name/type of disorder:_____

□ Medication Allergies:_____ Is child allergic to latex? NO YES

□ Other medical condition(s) you want the bus driver to know: _____

In emergency contact: Parent/Guardian:_____

Telephone(s) Home:_____ Work:_____ Cell:_____

Street Address: _____ City/town:_____

If unable to reach parent or guardian, contact:
Name:_____ Telephone: Home:_____ Work:_____ Cell:_____

Your child's Primary Care Physician's name: _____ Telephone:_____

********** FOR OFFICE USE ONLY**********
□Note for School Nurse: Send "Original" to Bus Transportation Coordinator, copy to student chart.

Bus Transportation Company:_____ Bus number:_____ LZ:MW 9/2017