# CAPE MAY COUNTY TECHNICAL HIGH SCHOOL

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

## Application for Admission — School Year 2020-21

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
___Early Childhood Development
___ Entertainment Production
___ Foods Production/ Commercial Foods
___ HVAC-R/Sustainable Energy
___Law Enforcement & Public Safety
___Natural Science Technology
___ Pre-Engineering Technology
___ Small Engine 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 | SBYS – School Based Youth Services (Activities & Clubs) |
| Soccer | FFA | Skills USA | |
| 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, health records and (if applicable) most recent IEP and/or 504 plan 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 shall provide equal and bias-free access for all students to all school facilities, courses, programs, activities, and services and give them maximum opportunity to achieve their potential regardless of race, creed, color, national origin, ancestry, age, sex, affectional or sexual orientation, gender identity or expression, marital status, nationality, socioeconomic status, disability, or pregnancy.

9/30/19

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)**

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 2020-21