



# CAPE MAY COUNTY TECHNICAL HIGH SCHOOL

188 CREST HAVEN ROAD, CAPE MAY COURT HOUSE, NJ 08210

(609) 465-2161, extension 691

Fax: 465-4978

[www.capemaytech.com](http://www.capemaytech.com)

## Application for Admission

## School Year 2012-13

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) Street/Number 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) \_\_\_\_\_  
Street/Number

City State Zip Code

Telephone No. ( ) \_\_\_\_\_ School Fax No. ( ) \_\_\_\_\_  
Area Code Area Code

### **Technical Program Major Desired:**

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

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> National Academy of Finance                | <input type="checkbox"/> Communications Arts Technology                     | <input type="checkbox"/> Heating/Cooling/Plumbing/Electrical |
| <input type="checkbox"/> Business Services Technology               | <input type="checkbox"/> Cosmetology  | <input type="checkbox"/> Law Enforcement & Public Safety     |
| <input type="checkbox"/> National Academy of Hospitality & Tourism  | <input type="checkbox"/> Culinary Arts                                      | <input type="checkbox"/> Masonry Technology                  |
| <input type="checkbox"/> Travel, Tourism and Marketing              | <input type="checkbox"/> Diesel/Small Engine Technology                     | <input type="checkbox"/> Natural Science Technology          |
| <input type="checkbox"/> National Academy of Information Technology | <input type="checkbox"/> Early Childhood Development                        | <input type="checkbox"/> Pastry/Baking Technology            |
| <input type="checkbox"/> Computer Technology                        | <input type="checkbox"/> Entertainment Production/<br>Music Arts Technology | <input type="checkbox"/> Pre-Engineering Technology          |
| <input type="checkbox"/> Agriscience & Horticultural Technology     | <input type="checkbox"/> Foods Production/Commercial                        | <input type="checkbox"/> Welding Technology                  |
| <input type="checkbox"/> Allied Medical Technology                  | <input type="checkbox"/> Graphic Arts                                       |  |
| <input type="checkbox"/> Automotive Mechanics Technology            |   |  |
| <input type="checkbox"/> Carpentry                                  |   |  |

Student's 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      | Fly Fishing Club | Mock Trial           | Strategy Games Club    |                         |
| Basketball    | Volleyball       | French Club          | National Honor Society | Student Government      |
| Cheerleading  | Floor Hockey     | Newspaper            | Tennis Club            | Academic Challenge Team |
| Cross Country | Aquaculture Club | HOSA                 | Peer Leadership        | Fitness Training        |
| Golf          | Drama Club       | Interact Skills Club | Robotics               | Yearbook                |
| Soccer        | FFA              | Key Club             | Skills USA             | School Based Youth      |
| Softball      | Surf Club        | Archery Club         | Spanish Club           | Services Activities     |
| Swimming      |                  |                      |                        |                         |

\_\_\_\_\_  
Last Name First Name Home Phone Cell Phone  
*Father/Guardian (Circle One)*

Occupation: \_\_\_\_\_ E-Mail: \_\_\_\_\_

\_\_\_\_\_  
Name & Address of Employer Work Phone Number

\_\_\_\_\_  
Last Name First Name Home Phone Cell Phone  
*Mother/Guardian (Circle One)*

Occupation: \_\_\_\_\_ E-Mail: \_\_\_\_\_

\_\_\_\_\_  
Name & Address of Employer Work Phone Number

I give my permission as parent/guardian to have academic, standardized tests, attendance, discipline, health and Child Study Team records released to the Cape May County Technical School District.

\_\_\_\_\_  
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.**

**WHEN YOU HAVE COMPLETED THE APPLICATION AND THE ATTACHED HEALTH FORM:**

Please bring or mail it to: 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.** No applications will be accepted after October 1, 2012. You will receive acknowledgment indicating receipt of the application and information about the next Admissions Placement Assessment. If you have any questions, please call the Admissions Office at 465-2161, ext. 691.

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.

Student Name: \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_ Current School: \_\_\_\_\_ Grade: \_\_\_\_\_

Is your child applying for enrollment in Cape May Technical School (check one):

- Full day high school program  Partial day (half day) career/technical, if so name of other school: \_\_\_\_\_  
 Student's Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Student's Dentist: \_\_\_\_\_ Telephone: \_\_\_\_\_

Does your child have Health Insurance?

- YES** \_\_\_ If Yes, name of insurance company: \_\_\_\_\_  
**NO** \_\_\_ If No, NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income families. The school may release my name and address to the NJFamily Care to contact me about health insurance.

Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

*Written consent required pursuant to 20U.S.C. & 1232g (b) (1) and 34 C.F.R. 99.30(b)*

**Check health conditions your child has:**

Only pertinent health information is shared with staff on a "need to know basis" unless otherwise directed by you or your child.

- Allergy to Medication(s): list \_\_\_\_\_  
 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 Blindness: Eye affected: Right Left  
 Color deficiency (also known as "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. List name of medication, dose and times taken, and reason/diagnosis): \_\_\_\_\_

**In the event of a medical emergency your child will be transported to the nearest hospital emergency room. Please complete the following information in the event your child is injured or ill.**

Parent/guardian Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 Street Town/City Zip code

Mailing address (if different from above): \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_

**In the event we are unable to reach you, contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home: \_\_\_\_\_ Work: \_\_\_\_\_

I give my permission for the school nurse to administer acetaminophen 650 mg. to my child for: headache, muscle aches, etc.

Parent/guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

**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 only if, your child has a medical condition you want the bus driver to know about.)*

Dear Parent/Guardian,

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. Please do not return this form with your child as such papers may be lost in transit.

Sincerely,  
Lynda Zipparo, School Nurse

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

Student's name (print): \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_ Grade: \_\_\_\_\_

Name of Bus Transportation Company: \_\_\_\_\_ Bus number: \_\_\_\_\_

Seizure Disorder List medications taken to control seizures, if any: Medication taken \_\_\_\_\_  
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.

9/2011