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Salem County Special Services School District
Student Referral/Application
2014-2015

Please identify SCSSSD placement option being considered:

☐ Alternative Middle & High School Programs **Contact:** Frank Maurer

☐ Behavioral Disabilities Programs - BD **Contact:** James D'Amato, Ph.D.

☐ Autism Spectrum Disorder Programs - ASD
☐ Cognitive Severe Programs - CS
☐ Pre-School Disabilities Programs - PSD
☐ Hearing Impaired Programs - DHH
☐ Multiply Disabled Programs - MD
☐ Transitional Career Programs - TCP

Contact: Todd Slim Ed.D- Cumberland Campus
Christopher Harris- Salem and Upper Pitts Campus

School and Program Locations:

Alternative ~HS/MS	Daretown Campus-~ BD	Cumberland Campus	Salem Campus (RDS)	Upper Pittsgrove Campus
		~ ASD, CS, MD, PSD,TCP	~ ASD, CS, MD, TCP	_~ ASD, DDH
Frank Maurer	**James D'Amato, Ph.D.**	**Todd Slimm Ed.D**	**Christopher Harris**	**Christopher Harris**
856-935-7552	856-358-2108	856-459-1061	856-769-0101	856-769-0101
Kendal Watson Sec	**Betsy Osterman-Sec**	**Judi Ware-Sec**	**Natalie Seiple-Sec**	**Natalie Seiple-Sec**
856-935-7552	**856-358-2108 x 5102**	856-459-1061 ext. 5012	856-769-0101 x 5360	856-769-0101 x 5360
118 Walnut Street	404 Daretown Road	13 Ramah Road	45 Cheney Road	235 Pine Tavern Road
Salem, NJ 08079	Elmer, NJ 08318	Bridgeton, NJ 08302	Mannington, NJ 08098	Monroeville, NJ 08343
856-935-7618 fax	856-358-0133 fax	856-459-1431 fax	856-769-3450 fax	856-769-3450 fax
fmaurer@scvts.org	jdamato@scsssd.net	tslimm@scsssd.net	charris@scvts.org	charris@scvts.org

STUDENT INFORMATION

Student Name:

______________________ ______________________ ______________________
Last Name **First Name** **Middle**

Address:

______________________ ______________________ ______________________
(If P.O. Box, list street address also) **City** **Zip Code**

Date of Birth:_____ **Age as of September 2014:** _____ **Grade:**_____

City of Birth:_____ **State of Birth: :**_____ **NJ-SMART #:** _____

Gender (Sex): ☐ **Male** ☐ **Female**

Race: ☐ **White** ☐ **Black** ☐ **Hispanic or Latino** ☐ **American Indian**
☐ **Pacific Islander** ☐ **Asian** ☐ **Multiracial**

Assessments: ☐ **ASK 3/4** ☐ **ASK 5/6** ☐ **ASK 7/8** ☐ **HSPA** ☐ **APA** ☐ **PARC**

Special Education Classification: _____ _____
Primary **Secondary**

Related Services Required: ☐ **Individual/Group Counseling** ☐ **OT** ☐ **PT** ☐ **Speech**

☐ **Special transportation accommodations** ☐ **One on one aide** ☐ **One on one nurse**

Limited English Proficiency (LEP): ☐ **Yes** ☐ **No**

If "Yes," identify primary language: :_____

Level of English Proficiency: Written: ☐ **Poor** ☐ **Fair** ☐ **Good** ☐ **Excellent**

Spoken: ☐ **Poor** ☐ **Fair** ☐ **Good** ☐ **Excellent**

Current Academic Levels (Grade Equivalent/GE): : _____ _____
Reading **Mathematics**

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Reason for Referral (Being brief, yet specific, please identify learning and/or behavioral difficulties leading to this referral):

_____

Pertinent Medical Information (Identify serious medical condition(s), daily medication, dosage, reason):

_____

PARENT/GUARDIAN INFORMATION

Parent(s)/Guardian(s): ________ ________________________________ ________________________

Telephone: Home ____ **Work** ____ **Cell** ____

Telephone: Home ____ **Work** ____ **Cell** ____

Emergency Contact: ____ **Emergency Telephone:**____

Limited English Proficiency (LEP): ☐ **Yes** ☐ **No**

If "Yes," identify primary language: ____

Level of English Proficiency: Written: ☐ **Poor** ☐ **Fair** ☐ **Good** ☐ **Excellent**

Spoken: ☐ **Poor** ☐ **Fair** ☐ **Good** ☐ **Excellent**

As of the Date of Referral, are parents/guardians aware of a possible change in placement?

☐ **Yes** ☐ **No**

If "Yes," describe level of parent/guardian acceptance or resistance:

____

COMMUNITY/AGENCY INVOLVEMENT

☐ **Psychotherapy** **Psychotherapist:** ____ **Telephone:** ____

☐ **Juvenile Probation** **Probation Officer:** ____ **Telephone:** ____

☐ **Other (Specify):**

RESIDENT/REFERRING DISTRICT INFORMATION

Resident School District: ____ **Referring District** (If different): ____

Case Manager: ____ **Title:** ____

Telephone: ____ **Extension:** ____

Signature: ________________________________ **Title:** ____ **Date:** ____

Referring District Representative

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CHECKLIST OF SUPPORTIVE DOCUMENTATION

To ensure that the Referral/Application is processed in a timely manner, please be certain to attach copies of the most current information available:

Student will not be accepted without the following information:

- ☐ **Current Individualized Education Program (IEP)**
- ☐ **Student Health Card (With up-to-date immunizations)**
- ☐ **Copy of students Birth Certificate**
- ☐ **Copy of Free/reduced Meal application.**
- ☐ **Most recent evaluation and goals for OT, PT and Speech.**
  - ☐ **OT Evaluation / Goals**
  - ☐ **PT Evaluation / Goals**
  - ☐ **SPEECH Evaluation / Goals**
- ☐ **Special Transportation** (circle appropriate) **Car Seat Booster Seat Harness Wheelchair Other: ____**
- ☐ **Current psycho-educational assessment reports administered within the past three years**

Check if attached:

- ☐ Psychiatric evaluation report, if any
- ☐ Printout of disciplinary actions and/or suspensions
- ☐ Up-to-Date Attendance printout
- ☐ Most recent report card
- ☐ Listing of credits earned to date (secondary students only)
- ☐ Behavior contracts, if any
- ☐ Functional behavioral assessment, if any
- ☐ Limited English Proficiency (LEP) students
  - ☐ Copy of home language survey ☐ English Language Proficiency Score
  - ☐ Testing accommodations
- ☐ Other relevant information attached (specify):

Please Note: COMPLETE information WILL expedite decision-making process.

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Medical Requirements for Students who attend the Cumberland or Salem (RDS) Campuses. Please read carefully and attach any required documents.

1. **Immunizations** – The state of NJ requires all students to have up-to-date immunization records, which are given to the school nurse prior to the student entering school.
2. **If beginning pre-K**, the student must have an influenza immunization, a recent physical and a PPD (if required).
3. **Physical** – The student must have a recent physical or one on the back of their A-45. If the student is medically fragile or at the discretion of the school nurse a more current physical may be required.
4. **PPD** (Tuberculosis test) – If coming from a high risk country the student must have a PPD prior to attending.
5. **If the student is on oxygen,** the school requires an order from the doctor and written consent from the parent to administer
6. **If the student has portable oxygen**, the student must have appropriate equipment for bus transportation and school safety. All supplies must accompany the child.
7. **If the student is non-ambulatory**, a stroller or wheelchair, that is transportable, must accompany the student on the bus.
8. **If the student is on any mediation**, prn (as needed) or otherwise, they must have an order from the doctor, written consent from the parent/guardian and all medication must be brought in , in its original container with the child's name on it.
9. **If the student is G-tube fed**, they must have an order from the doctor for the feeding and flushing, and all supplies sent in with the student.
10. **If the student has a g-tube**, there must be an order that the G-tube may be replaced or changed prn (as needed) and there must be an extra G-tube kit sent it or one kept in the child's back pack to go back and forth with the student every day.
11. **If the student is G-tube fed and the doctor wants them orally fed**, the school requires a recent swallowing study and specific orders from the doctor along with written consent from the parent/guardian.
12. **If the student needs to be suctioned**, the school requires an order from the doctor and written consent from the parent/guardian along with all supplies needed.
13. **If the student has a tracheotomy,** the school requires a doctor's order to replace it prn (as needed), written consent from the parent/guardian along with all supplies needed (including an extra tracheotomy tube).
14. **If the student has a vagal stimulator**, the school requires an order from the doctor to use a magnet, when to use it and written consent from the parent/guardian.
15. **If the child has a nebulizer treatment**, the school requires an order from the doctor with specific instructions (Asthma Action Plan), medication sent in, in its original container with the student's name on it and written consent from the parent/guardian.

Student's Name: ____ DOB: ____

Parent/Guardian: ____ Phone #: ____

CST Name: ____ CST Phone #: ____

CST Email Address: ____ Sending District: ____