

CONFIDENTIAL

**Salem County Special Services School District
Student Referral/Application
2016-2017**

**Send to the District Registrar
Judi Ware-District Office
880 Route 45, Woodstown, NJ 08098
856-769-0101 ext 5358
Fax 856-769-3602
jware@scsssd.net**

School and Program Locations

<p>Alternative ~ HS/MS CDS Code:33-4635-301 Shawn Rebman 856-351-2238 srebman@scsssd.net</p> <p>Kendel Watson-Sec 856-351-2237 kwatsonr@scvts.org 460 Hollywood Avenue c/o Davidow Hall Carney's Point, NJ 08069</p>	<p>Daretown Campus ~ BD CDS Code:33-4635-050 James D'Amato, Ph.D. 856-358-2108 jdamato@scsssd.net</p> <p>Betsy Osterman-Sec 856-358-2108 x 5102 bosterman@scsssd.net Daretown Road Elmer, NJ 08318 856-358-0133 fax</p>	<p>Cumberland Campus ~ ASD, ID, MD, PSD CDS Code:33-4635-300 Todd Slimm, Ed.D 856-459-1061 tslimm@scsssd.net</p> <p>Michelle Smith-Sec 856-459-1061 x 5012 msmith@scsssd.net 13 Ramah Road Bridgeton, NJ 08302 856-459-1431 fax</p>	<p>Upper Pittsgrove Campus ~ ASD CDS Code:33-4635-300 Jane Whittinghill, Ed.D 856-769-0101 x 5202 jwhittinghill@scsssd.net</p> <p>Michelle Smith-Sec 856-459-1061 x 5012 msmith@scsssd.net 235 Pine Tavern Road Monroeville, NJ 08343 856-769-3450 fax</p>	<p>Salem Campus (RDS) ~ ASD, MD, TCP CDS Code:33-4635-009 James Helder 856-769-0101 jhelder@scsssd.net</p> <p>Natalie Seiple-Sec 856-769-0101 x 5360 nseiple@scsssd.net 45 Cheney Road Mannington, NJ 08098 856-769-3450 fax</p>
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Please identify SCSSSD placement option being considered:

Alternative Middle & High School Programs **Contact: Shawn Rebman**

Behavioral Disabilities Programs – BD **Contact: James D’Amato, Ph.D. – Daretown Campus**

Pre-School Disabilities Programs – PSD **Contact: Todd Slimm, Ed.D - Cumberland Campus**
 Autism Spectrum Disorder Programs – ASD
 Multiply Disabled Programs – MD (Elementary, Middle, High School)
 Intellectually Disabled (Mild, Moderate, Severe) –ID

Autism Spectrum Disorder Programs – ASD **Contact: Jane Whittinghill, Ed.D - Upper Pittsgrove Campus**

Multiply Disabled Programs – MD **Contact: James Helder - Salem Campus (RDS)**
 Autism Spectrum Disorder Programs - ASD
All High School Students receive Transitional Career Programs as part of their program - TCP

Extended School Year Only (Please also indicate desired program above)

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STUDENT INFORMATION

Student Last Name Student First Name Student Middle Name

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

Date of Birth: Age as of September 2016: Grade:

City of Birth: State of Birth:

Gender (Sex): Male Female NJ-SMART SID #:

Ethnicity/Race: White Black Hispanic or Latino American Indian
Pacific Islander Asian Multiracial

Language Spoken at Home: Migrant Status (if applicable):

Homeless location (if applicable):

Note: Student lacks a fixed, regular, and adequate residence, pursuant to N.J.A.C. 6:5-1.3.

Assessments: ASK Science 4/8 APA, Science 4/8/ Bio PARCC DLM

Special Education Eligibility Category: Primary Secondary

Related Services Required: Individual/Group Counseling OT PT Speech

Special transportation accommodations One-on-one aide One-on-one nurse

Classroom nurse Shared aide

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:

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):

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PARENT/GUARDIAN INFORMATION

Parent(s)/Guardian(s) Name: _____

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

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

Emergency Contact Name _____ Emergency Telephone: _____

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: _____

DCP & P Case Worker: _____ Telephone: _____

Other (Specify): _____ Telephone: _____

RESIDENT/REFERRING DISTRICT INFORMATION

Resident School District: _____ Referring District (If different): _____

Resident School District CDS Code: (4 digits) _____ School CDS Code: (3 digits) _____

District responsible for Tuition: _____
Application will not be processed without this information.

Case Manager: _____ Title: _____

Telephone (Work): _____ Extension: _____

Cell Phone: _____ Email: _____

To the best of my knowledge, all information included in this application is true and complete.

Signature:
Referring District Representative

Title:

Date:

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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's.
- 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 medication**, daily, prn (as needed), over the counter, **they all 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.

CST Name

CST Phone #:

CST Email Address:

Sending District:

Salem County Special Services offer equal opportunity to qualified individuals, regardless of race, creed, color, national origin, ancestry, marital status, affectional/sexual orientation, gender, religion, disability, English proficiency, immigration status, housing status or socioeconomic status.