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Salem County Special Services School District
Student Referral/Application
2017-2018

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

Alternative ~ HS/MS	Daretown Campus ~ BD	Cumberland Campus	Upper Pittsgrove Campus	Salem Campus (RDS)
CDS Code:33-4635-301 **Shawn Rebman** 856-351-2238 srebman@scsssd.net **Kendel Watson-Sec** **856-351-2237** *kwatsonr@scvts.org* 460 Hollywood Avenue c/o Davidow Hall Carney's Point, NJ 08069	***CDS Code:33-4635-050*** **James D'Amato, Ph.D.** 856-358-2108 *jdamato@scsssd.net* **Betsy Osterman-Sec** **856-358-2108 x 5102** bosterman@scsssd.net Daretown Road Elmer, NJ 08318 856-358-0133 fax	**~ ASD, ID, MD, PSD** ***CDS Code:33-4635-300*** **Todd Slimm, Ed.D** 856-459-1061 *tslimm@scsssd.net* **Michelle Smith-Sec** **856-459-1061 x 5012** msmith@scsssd.net 13 Ramah Road Bridgeton, NJ 08302 856-459-1431 fax	**~ ASD** ***CDS Code:33-4635-300*** **Jane Whittinghill, Ed.D** 856-769-0101 x 5202 Jwhittinghill@scsssd.net **Jean Pilieri-Sec.** **856-769-0101 x5204** jpilieri@scsssd.net 235 Pine Tavern Road Monroeville, NJ 08343 856-769-3450 fax	**~ ASD, MD, TCP** ***CDS Code:33-4635-009*** **James Helder** 856-769-0101 *jhelder@scsssd.net* **Natalie Seiple-Sec** 856-769-0101 x 5360 *nseiple@scsssd.net* 45 Cheney Road Mannington, NJ 08098 856-769-3450 fax

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 2017:** _____ **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: **Title:** **Date:**
Referring District Representative

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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: <u>COMPLETE information WILL expedite decision-making process</u>.

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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.