

SPECIAL SERVICES Admission Information

Ocean County Vocational Technical School is proud of the accomplishments we have achieved in providing vocational training programs for students with special educational needs. Our school offers shared-time (half day) specialized vocational training for Special Needs students at four of our six vocational centers. Our goals are to prepare Special Needs students for the world of work and obtain skills for daily living.

Vocational Evaluation

The Evaluation Unit is a work oriented environment designed to help students grades eight through twelve make a sound vocational selection by: exploring the world of work relative to definite vocational areas; assessing the student's ability to do work; determining general areas of vocational interest and aptitudes; and identifying an appropriate vocational program for the student.

The Evaluation Unit operates on a shared-time concept (half day at the home school - half day at the unit) The evaluation process generally takes up to seven days to complete. This program will provide comprehensive evaluation and a meaningful experience for the participating students.

Scholarship Information

Scholarship awards are available to exemplary students of the current graduating class for continuing education at OCVTS. A limited number are made available each year to qualified seniors.



**CALL AN OCVTS ADMISSIONS REPRESENTATIVE AT
732.473.3100 EXT. 3326
FOR ASSISTANCE WITH THIS APPLICATION**

MISSION STATEMENT

The mission of the Ocean County Vocational Technical School system is to prepare students for job placement or further education leading to successful employment. We develop partnerships with affiliated schools, parents, business, industry and community agencies to create and deliver opportunities for students to participate in quality occupational programs and support services. These programs and services are designed to meet the needs of high school students and adult learners, as well as the requirements of employers, colleges, technical schools and the community. All students will achieve the New Jersey Core Curriculum Content Standards at all grade levels.

Our most important products are our quality graduates and our most important service is to provide them with skills for a lifetime. We measure our success by: enrollment in our programs; student attainment of marketable occupational skills; graduates capable and desirous of life-long learning; employer and graduate satisfaction; cost effectiveness of our total system; achievement of our graduates and organizational and individual recognition and awards received.

It is the policy of the Board of Education of Ocean County Vocational Technical School not to discriminate in its technical programs, vocational opportunities, activities, employment practices or admission policies and practices on the basis of race, color, creed, religion, sex, ancestry, national origin, affectional and sexual orientation, disability or social or economic status. Lack of English language skills will not be a deterrent to admission to any program at the Ocean County Vocational Technical School. Inquiries regarding affirmative action, discrimination (including Federal Title IX requirements), sexual harassment or equity should be directed to:

Nancy Weber-Loeffert, Title IX/Affirmative Action Officer, 732.240.6414 (ext. 3332)
Thomas McInerney, Federal Section 504 Officer, 732.286.5665 (ext. 3412)
Kevin Dineen, Americans with Disabilities Act (ADA) Officer, 732.473.3100 (ext. 3123)

**OCVTS is an Equal Opportunity School District.
The Carl D. Perkins Vocational Technical Education Act provides partial funding for this publication.
Visit our website at www.ocvts.org**

Revised November 2010

Application for SPECIAL SERVICES



FOR OCVTS USE ONLY			FOR OCVTS USE ONLY		
OCVTS Eval.	Class. Date	Class.	Program	Center	Session AM PM
_____	_____	_____	_____	_____	_____
Date of Session Requested _____			Home School _____		

This application and the Medical Summary Form must be completed and signed by the parent or guardian and returned to the Home School Child Study Team (CST). The Child Study Team Form may only be completed by the Home School Child Study Team or approved school personnel.

PLEASE PRINT ALL INFORMATION CLEARLY

Student's Last Name _____ First Name _____ Middle Initial _____

Student's Primary Residence Mailing Address - Street / PO Box _____

City _____ State _____ Zip Code _____

Student's Date of Birth _____ Age _____ City of Birth _____ State of Birth _____ Country of Birth _____

Male Female _____
Grade Upon Entering _____

Parent's Home Phone Number (Include Area Code) _____ Parent's Email Address _____

Check One Mother or Guardian Name _____ Business Phone Number (Include Area Code) _____ Cell Phone Number (Include Area Code) _____

Check One Father or Guardian Name _____ Business Phone Number (Include Area Code) _____ Cell Phone Number (Include Area Code) _____

How did you learn about OCVTS? School Presentation Print Advertisement Mail Radio Other, please explain: _____

School Medical Authorization Agreement

Your child will be required to use various tools and equipment. Appropriate instruction in the proper use of the tools and equipment is given and close supervision is maintained. Every precaution is taken to prevent accidents. We are asking your cooperation in impressing your child with the importance of being careful. It is mandatory that all students accept the obligation to obey the safety rules designed to protect them and others. I hereby verify that all the medical information provided in this document is accurate and do authorize the school nurse and/or appropriate school personnel to render whatever aid is deemed necessary for the safety of my child. I also give permission to share this information with appropriate school and medical personnel and for my child to use the tools and equipment in the program. I further understand that it is my responsibility to immediately report any health changes to the School Nurse. In an emergency situation you have my permission to send my child to the nearest hospital.

School Permit for Educational Field Trips

I approve the participation of my son/daughter in school sponsored educational trips with his/her career program. I understand that such trips will be properly supervised by a member of the faculty and that advanced notice about the activity will be made available. I agree to instruct my child to follow all directions concerning good behavior, safety and special procedures.

School Publicity Release

I understand that my child may occasionally be the subject of individual or group photographs or videos taken in his/her career area. I approve the use of my child's image in various media including, but not limited to newspapers, television and electronic media to be used in the promotion of programs at the Ocean County Vocational Technical School.

Student records will be retained on file for a period of two years after student leaves Ocean County Vocational Technical School. I understand that a criminal background check will be required for all students over the age of 18 in health career programs. By signing below, I accept all of the above agreements and agree to abide by all school policies, safety rules and procedures.

Print Name - Check One Parent Guardian _____ Parent's Signature _____ Date _____

Print Student Name _____ Student's Signature _____ Date _____

N.J.A.C. 6:3-2.2 allows educational, occupational, and military personnel access to school information. If you do not want this information released, please initial here _____

Survey in Compliance with Affirmative Action Program (Optional)		
Ethnic Origin		
<input type="checkbox"/> White	<input type="checkbox"/> Black	<input type="checkbox"/> Hispanic
<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Cuban	<input type="checkbox"/> Native American or Alaskan
<input type="checkbox"/> Asian or Pacific Islander	<input type="checkbox"/> Other	<input type="checkbox"/> No Response



Medical Form

This form to be completed by Parent/Guardian
This form will not be processed if incomplete.

Student's Last Name _____ First Name _____
 Please complete the following medical summary for your child's medical file. Indicate any existing condition by marking the appropriate boxes below. Explain any of the conditions in the explanation fields below. All information is confidential and will not in any way affect admission to OCVTS, as per section 504 of the Rehabilitation Act of 1973.

- | | | |
|---|--|---|
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Drug Allergy (Specify) | <input type="checkbox"/> Learning Disability (Specify) |
| <input type="checkbox"/> Allergies(Specify) | <input type="checkbox"/> Eating Disorder (Specify) | <input type="checkbox"/> Lyme Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Muscle Disorder (Specify) |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Nerve Disorder (Specify) |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Excessive Bruising | <input type="checkbox"/> Physical Handicap (Specify) |
| <input type="checkbox"/> Color Blind | <input type="checkbox"/> Glasses | <input type="checkbox"/> Respiratory Problems (Specify) |
| <input type="checkbox"/> Contacts | <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Vision Problems (Specify) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems (Specify) | |

Other _____

Explain Checked Areas Here: _____

Date of Last Physical Exam: _____ Date of Last Polio Immunization _____ Date of Last Lead Blood Test _____

If your child takes any medication on a regular basis, please list medication name(s) below.*

MEDICATION NAME	EXPLAIN REASON FOR MEDICATION

**If it is necessary for your child to take any medication in school, it must be brought to the School Nurse by the parent, guardian or adult designee. No student is allowed to carry prescription or non-prescription medication on their person unless it has been approved by a Licensed Physician, the School Nurse, all paperwork has been completed and said paperwork is on file at the school. Any authorized medications will be held at Ocean County Vocational Technical School for parent, guardian or adult designee to pick up.*

List required medical information below. If you do NOT have health insurance indicate by writing "NONE".

Physician's Name _____ Office Phone (include area code) _____

Name of Health Insurance _____ Policy Number _____ Group Number _____

In case of emergency, please indicate, where student's parent or guardian may be reached during school hours:

Mother's Name _____ Business Phone (include area code) _____ Cell Phone (include area code) _____

Business Address _____

Father's Name _____ Business Phone (include area code) _____ Cell Phone (include area code) _____

Business Address _____

List two adults who are authorized to pick up your child and be responsible for them if you cannot be reached:

Name _____ Phone _____

Address _____

Name _____ Phone _____

Address _____

Child Study Team Information

This form is to be completed by the home school Child Study Team or approved high school personnel ONLY.
This form will not be processed if incomplete.

PLEASE PRINT ALL INFORMATION CLEARLY

Student's Last Name _____ First Name _____ Middle Initial _____
 High School _____ NJ Smart Identification Number (SID) _____
 CST / Counselor _____ Phone Number _____ Extension Number _____

Latest HSPA Test Results*	AREA	SCORE*	YEAR TAKEN	Attendance (Days Absent)	Grade 9	Grade 10	Grade 11
	Reading*						
	Math*						
	Writing*						

**If student failed any of these areas, please include a testing profile.*

- | | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | This student needs Matrix Science Credits |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | This student needs Matrix Math Credits |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | This student needs Matrix Language Arts Credits |

- | | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | This student is a Classified student (CST) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | This student has completed the OCVTS Evaluation Unit |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | This student is exempt from the HSPA |

A copy of the student's complete record, including test data, school grades, and a health form completed by the nurse (if necessary) must be attached to this application. All above information must be filled in prior to forwarding.

Additional Information: Please provide any other pertinent information or personal comment that does not appear on the copy of the student records, i.e., personality traits, social development, strengths, weaknesses, etc. (Use an additional sheet, if necessary).

Signature of Counselor _____ Date _____

APPLICATION FOR EVALUATION PROGRAM

PLEASE INDICATE CLASSIFICATION AND DATE OF CLASSIFICATION

Date of Session Requested _____

Student Classification _____ Classification Date _____

Application submitted by _____ Date _____

Phone Number to Contact for Additional Information _____

THE FOLLOWING INFORMATION IS ATTACHED:

- | | |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Student Transcript | <input type="checkbox"/> Yes <input type="checkbox"/> No Individual education Plan |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Child Study Team Records | <input type="checkbox"/> Yes <input type="checkbox"/> No Health Summary |

Reason for Evaluation: _____

Indicate which school register this student is placed in: REGULAR SPECIAL REGISTER SUPPLEMENTAL REGISTER