December 13, 2018

To Whom It May Concern:

The Summer Twilight Program at Somerset County Vo-Tech is offering free career technical education and academic training to youth in Somerset County, ages 14 – 18. Career training will be offered in the following areas: Auto Body, Auto Mechanics, Cosmetology, Culinary, Photography and New-Urban Moves (Dance). In addition to career education, our program provides sixty minutes per day instruction in the areas of mathematics, language arts literacy, and pre-employment/career and life skills. Twilight serves capable youth in need of additional support services due to certain life circumstances that may include: attendance problems, low income, discipline problems, problems at home, etc.

The Summer Twilight Program will be held Monday, July 1, 2019 – Thursday, July 25, 2019, from 8:00 a.m. until 1:00 p.m., Monday through Thursday only. The program will be closed on Thursday, July 4, 2019. Lunch is provided and participants will receive an hourly stipend of $6.25 for a total of 4 hours each day. Transportation will be provided for participants living in Franklin Township, South Bound Brook, Manville, Somerville, and other locations in the county depending on need. Please note that the number of students served is contingent upon funding.

Applicants are required to submit a completed application. Please note that the applicant’s school must fill out the reverse side of the Vo-Tech application. We are requiring that all sending school districts supply standardized test scores, academic records, important health forms and discipline records. Incomplete applications will not be processed. Applications must be submitted no later than March 15, 2019. Any student that cannot commit to the full 15 days of the program is not eligible for participation (i.e. vacation, summer school, summer camp, etc.)

Work boots are required for Auto Body and Auto Mechanics. Also, non-slip shoes are required for Culinary. Please note that Twilight is committed to providing a safe environment for all students. Therefore, students are prohibited from wearing clothing and displaying hand gestures that could be interpreted with gang affiliation. Please refer to the next page for a more detailed dress code.

Thirty-five years of experience has shown us that the students who most benefit from the program are those who have family and school/agency counselors that work closely with the Twilight Program Staff. We encourage and welcome everyone’s help and support.

If you have any questions please contact our Twilight recruiter Nzinga Basir at 908-526-8900, ext. 7297 or e-mail at nbashi@scvths.net

Sincerely,

Diane M. Ziegler
Principal/Twilight Director
APPLICATION FOR THE 2019 SUMMER TWILIGHT PROGRAM

STUDENT INFORMATION
Please Print

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<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MIDDLE NAME</th>
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<tr>
<th>HOME ADDRESS</th>
<th>CITY</th>
<th>STATE</th>
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<tr>
<th>DATE OF BIRTH</th>
<th>GRADE</th>
<th>MALE / FEMALE</th>
<th>HOME PHONE NUMBER</th>
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<th>* ( ) FATHER'S NAME</th>
<th>DAYTIME PHONE #</th>
<th>CELL PHONE #</th>
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<th>* ( ) MOTHER'S NAME</th>
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<th>CELL PHONE #</th>
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<th>EMERGENCY CONTACT</th>
<th>DAYTIME PHONE #</th>
<th>RELATIONSHIP</th>
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<tr>
<th>PARENT E-MAIL ADDRESS</th>
<th>SPECIAL DIETARY RESTRICTIONS</th>
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* ( ) IF APPLICABLE, PLEASE PUT A CHECK TO INDICATE THE PERSON (S) WITH WHOM THE STUDENT RESIDES.

PARENT AUTHORIZATION

I hereby authorize SCVTHS's Linkages School-Based Youth Services Program to provide services including job placement, life skills education, community support, crisis intervention, supportive counseling, substance abuse education and counseling, health education (birth control is NOT provided by the Linkages Program), and recreation. A student will receive services from Linkages only if the student asks for services and/or is referred for services by their parent/guardian, a school administrator or faculty member, or an outside agency providing services to the student.

X

PARENT SIGNATURE REQUIRED DATE

SOMERSET COUNTY VOCATIONAL SCHOOL DISTRICT'S AFFIRMATIVE ACTION POLICY
To provide equal educational opportunities regardless of sex, race, color, religion, ancestry, national origin, age, sexual orientation, handicap, or socioeconomic status. Contact Teresa Morelli, Title IX & Affirmative Action Officer, 908-526-8900. Ext. 7167. Inquiries regarding Section 504, Rehabilitation Act of 1973 (PL 93-112) contact Patrick Pelliccia, 504 Coordinator, 908-526-8900 Ext. 7231
SENDING DISTRICT INFORMATION

SENDING SCHOOL DISTRICT ______________________ YEAR OF GRADUATION ______________________ GUIDANCE COUNSELOR ______________________

PLEASE INDICATE YOUR PREFERENCES BY NUMBERING 1, 2, AND 3.

___ AUTO BODY ______________________  ___ AUTO MECHANICS ______________________  ___ COSMETOLOGY ______________________
___ CULINARY ______________________  ___ PHOTOGRAPHY ______________________  ___ URBAN MOVES (DANCE)* ______________________

* Will require a follow-up phone questionnaire with coordinator

ACADEMIC RECORD: PLEASE ATTACH COPIES OF PARCC TEST RESULTS

___ CHECK HERE IF THE STUDENT HAS A "504" PLAN (IF SO, PLEASE ATTACH)
___ CHECK HERE IF THE STUDENT IS RECEIVING ESL SUPPORT SERVICES
___ CHECK HERE IF ESL IS RECOMMENDED

WHAT IS THE PRIMARY LANGUAGE SPOKEN AT HOME? __________________________________

ATTENDANCE & DISCIPLINE RECORDS:

PLEASE ATTACH PRINT OUTS OF ALL RECORDS OF ATTENDANCE AND DISCIPLINE.

X__________________________________________ DATE ______________________

VICE PRINCIPAL'S SIGNATURE ______________________

SPECIAL SERVICES:

HAS THIS STUDENT BEEN CLASSIFIED BY THE CHILD STUDY TEAM? NO_______ YES_______ (If yes, please provide copy of IEP)

HAS THIS STUDENT BEEN DE-CLASSIFIED BY THE CHILD STUDY TEAM? NO_______ YES_______ (If yes, please explain below)

X__________________________________________ DATE ______________________

DIRECTOR OF SPECIAL SERVICES SIGNATURE ______________________

SENDING DISTRICT COUNSELOR'S CHECKLIST

I VERIFY THE FOLLOWING INFORMATION IS COMPLETE/ACCURATE & ALL OF THE FOLLOWING FORMS HAVE BEEN INCLUDED FOR REVIEW.

___ A-45 STATE HEALTH FORM ______________________  ___ HEALTH OFFICE EMERGENCY FORM ______________________
___ ATTENDANCE RECORDS ______________________  ___ PARENT SIGNATURES ______________________
___ SPECIAL SERVICES INFORMATION ______________________  ___ DISCIPLINE RECORDS (Report from student database) ______________________
___ TRANSCRIPTS AND/CR REPORT CARD ______________________  ___ COPIES OF ALL STANDARDIZED TEST SCORES ______________________

X__________________________________________ DATE ______________________

COUNSELOR'S SIGNATURE ______________________
Somerset County Vocational & Technical High School
Twilight Program
Dress Code

Students are expected to be neat and clean in appearance, and to wear appropriate dress for
school.

Unacceptable dress includes, but is not limited to:

- Garments that violate shop safety guidelines
  - This includes baggy clothing (pants not properly belted at waist, excessively long shirts)
- See through garments
- Halter tops, tube tops
- Men’s sleeveless tanks with large armholes that do not cover the torso & female
tanks with less than 3-finger width straps
- Low-cut and/or tight fitting blouses/tops
- Bare midriffs (tops and shirts must be long enough so the midriffs are not exposed)
- Mini skirts, mini shorts (length of dresses/shorts should be no higher than 4
  inches above the knee)
- Visible undergarments
- Bandanas, caps, hats, hoods, doo-rags
- Sunglasses
- Items with pictures, emblems or writings on clothing or on the body that are:
  - Lewd, offensive, vulgar or obscene (for example: profanities, ethnic or
    racial slurs, etc.)
  - Advertise or depict tobacco products, alcoholic beverages, drugs, or any
    other prohibited substance
- Students are prohibited from wearing clothing and displaying hand gestures that
  could be interpreted with gang affiliation
  - Beads, bandanas, doo-rags, red/blue shirts
- Electronic devices will be brought at the risk of the student. SCVTHS staff is
  not responsible for lost or stolen electronic devices.

The Administration will determine the appropriateness of one’s clothing if there is a question.

Students in violation of dress code policy are not permitted to attend class unless clothing is
changed. Absence from classes may jeopardize a successful completion of the program.

Parent Signature_________________________________________ Date___________
Household Annual Income

REQUIRED

Please note that household income does not affect acceptance into the program.
The information below is required by Twilight’s funding sources.

Applicant Name:  

Total Number in Household:  

Approximate Household Annual Income:  

Race/Ethnicity: (Please indicate by marking a box or writing in the ethnicity)

<table>
<thead>
<tr>
<th>White</th>
<th>Black/African American</th>
<th>Asian</th>
<th>Hispanic/Latino</th>
<th>Native American</th>
<th>Other (please specify)</th>
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</thead>
</table>

Household Annual Income:

(In column 1, circle your household size; in column 2, circle your annual income range.)

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<tr>
<th>Household Size</th>
<th>Annual Income Range</th>
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<tbody>
<tr>
<td>1</td>
<td>$13,500 and below</td>
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<tr>
<td>2</td>
<td>$13,501 - $18,000</td>
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<tr>
<td>3</td>
<td>$18,001 - $22,000</td>
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<tr>
<td>4</td>
<td>$22,001 - $26,000</td>
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<tr>
<td>5</td>
<td>$26,001 - $31,000</td>
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<tr>
<td>6</td>
<td>$31,001 - $36,000</td>
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<tr>
<td>7</td>
<td>$36,001 - $40,000</td>
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<tr>
<td>8</td>
<td>$40,001 - $45,000</td>
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<tr>
<td>9 and over</td>
<td>Over $45,000</td>
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</tbody>
</table>
PUBLICITY RELEASE FORM

The Somerset County Vocational & Technical Schools use photographs of students in promotional materials to showcase particular programs and to attract new students. These materials include newsletters, brochures, advertisements and our school website. As a school community we want to celebrate your child and his/her work and accomplishments. The law requires that we ask for your permission to use your child’s likeness and/or name in our school materials.

By signing this document, I give permission to Somerset County Vocational & Technical Schools to use photographs and other visual records of the student named below in promotional media, including the internet. I understand that I am giving permission for the entire period of my child’s enrollment at SCVTS and that I can revoke this permission, if given below, by written notice at any time.

Please check only ONE below:

( ) YES, I give permission for my child’s likeness and name to be used in Somerset County Vocational & Technical Schools’ publication media;

( ) YES, I give permission for my child’s likeness only to be used in Somerset County Vocational & Technical Schools’ publication media;

( ) YES, I give permission for my child to be identified by name only in Somerset County Vocational & Technical Schools’ publication media;

( ) NO, I do not give permission for my child’s likeness and name to be used in Somerset County Vocational & Technical Schools’ publication media;

________________________________________________________
PLEASE PRINT STUDENT NAME

________________________________________________________
PLEASE PRINT PARENT/GUARDIAN NAME  EMAIL ADDRESS

________________________________________________________
PARENT/GUARDIAN SIGNATURE  DATE
HEALTH OFFICE EMERGENCY FORM

Please use PEN & PRINT CLEARLY

Name: ___________________________ Home Phone: ___________________________

Last  First  M.I. 

Home Address: ___________________________ 
Street or P.O. Box: __________________ City: ___________ Zip: ___________

Mailing Address (if different): ___________________________ 
Street or P.O. Box: __________________ City: ___________ Zip: ___________

City of Birth: __________________ State of Birth: __________________ Country of Birth: __________________

Age: _______ Birth Date: _______ / _______ / _______ Grade: _______ CTE Program: __________________ Full Time _______ Share Time _______

Please Circle RACE:  • White  • Black  • Hispanic  • Asian  • American Indian  • Native Alaskan  • Native Hawaiian
  • Pacific Islander

Father/Guardian’s Name: ___________________________ Contact Phone # Home: ___________________________
Cell: ___________________________ Email: ___________________________

Mother/Guardian’s Name: ___________________________ Contact Phone # Home: ___________________________
Cell: ___________________________ Email: ___________________________

Other approved Emergency Contacts (Neighbor, Relative, etc):

(1) Name / Relationship ___________________________ Phone # ___________________________

(2) Name / Relationship ___________________________ Phone # ___________________________

(3) Name / Relationship ___________________________ Phone # ___________________________

(4) Name / Relationship ___________________________ Phone # ___________________________

Doctor’s Name: ___________________________ Phone #: ___________________________

Dentist’s Name: ___________________________ Phone #: ___________________________

Please list any Medical/Surgical Care your child has received during the past year: ___________________________

Existing Conditions:  ( ) Asthma  ( ) Diabetes 1 or 2  ( ) Heart Condition  ( ) Seizure Disorder  ( ) Epi-pen for:
( ) IBS  ( ) Eating Disorder  ( ) Anxiety Attacks
( ) Other – Please Explain: ___________________________

Dental Exam: ___________________________ Eye Exam: ___________________________ Allergies-Kind: ___________________________ Medications: ___________________________

Date / Braces ___________________________ Date / Glasses / Contacts ___________________________

Immunizations/Tetanus: ___________________________ Allergic Reaction-Date: ___________________________ Restrictions: ___________________________

Additional information to aid us in an Emergency: ___________________________

(Use Other Side if Necessary)

PLEASE NOTE: Parent/Guardian Signature Is Required for BOTH Boxes:

Do you have Medical Insurance? Yes____  No____  If Yes, Company Name: ___________________________

Note: NJ Family Care provides free or reduced health insurance for uninsured children & certain low income parents.
For more information call 800-701-0710 or visit www.njfamilycare.org to apply online. You may release my name & address to the
NJ Family Care Program to contact me about health insurance.

Parent/Guardian Signature: ___________________________ Printed Name: ___________________________ Date: _______

Written consent required pursuant to 20 u.s.c. & 1232g (b)(1) and 34;C.F.R.

I, the undersigned, do hereby authorize officials of New Jersey Public Schools to contact directly the persons named on this card and do
authorize the named physicians to render such treatment as may be deemed necessary in an emergency or the health of said child. In
the event that physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized
to take whatever action is deemed necessary, in their judgment, for the health of the aforesaid child.
( ) Please check this box if there has been a name change of a Parent/Guardian or Telephone Number(s).

Parent/Guardian Signature: ___________________________ Printed Name: ___________________________ Date: _______

PLEASE NOTE: Medical Information may be shared with school personnel, on a need-to-know basis, when indicated to protect your child's health.

HDE_2011
### VACCINE TYPE

<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>1st Dose Mo/Day/Yr</th>
<th>2nd Dose Mo/Day/Yr</th>
<th>3rd Dose Mo/Day/Yr</th>
<th>4th Dose Mo/Day/Yr</th>
<th>5th Dose Mo/Day/Yr</th>
<th>LEAD SCREENING</th>
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<tr>
<td>Diphtheria, Tetanus, Pertussis (DTaP) or any combination</td>
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<tr>
<td>Polio—Inactivated Polio Vaccine (IPV)</td>
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<td>If oral vaccine, indicate (OPV) in corner box</td>
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<tr>
<td>Measles, Mumps, Rubella (MMR)</td>
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<tr>
<td>Haemophilus B (Hib)**</td>
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<td>Hepatitis B</td>
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<td>Varicella</td>
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<td>Pneumococcal Conjugate **</td>
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<td>Meningococcal</td>
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<td>Hepatitis A ***</td>
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<td>HPV (Human Papillomavirus) ***</td>
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<td>Other</td>
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<td>Other</td>
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### Medical History

- **Food Allergies:**
  - Diabetest
  - Lyme Disease
  - Juvenile Rheumatoid Arthritis
- **Non-Food/Non-Drug Allergies:**
  - Influenza (Flu)
  - Mononucleosis
  - Autism Spectrum Disorders
- **Asthma:**
  - Drug Allergies
  - Chronic Otitis Media
  - ADHD
- **Congenital Disorder:**
  - Heart Disease
  - Auto Immune Disorders
  - Concussion/TBI
- **Conjunctive Disorder:**
  - Hepatitis
  - Strep Infections

**Health Screening Code:** N = Normal; R = Referred; T = Under Treatment; C = See Comments

### Physical Examination

- **Grade/Age:**
- **Date:**
- **Height:**
- **Weight:**
- **BMI:**

### Vision

- **With Correction:**
  - R
  - L
  - BOTH
- **Without Correction:**
  - R
  - L
  - BOTH

### Muscle Balance

### Color Perception

- **Date:**
- **Results:**

### Biennial Scoliosis Screening

- **Date:**
- **Result:**

### TB Screening (Mantoux or IGRA Test)

- **Tested:**
- **Read:**
- **Mantoux Result (MM) or IGRA Result:**

**Required for Daycare Care Enrollees 0-2 Months (5th Birthday Only)**

**Not Required**

A-45 STATE OF NEW JERSEY DEPARTMENT OF EDUCATION DEPARTMENT OF HEALTH

Revised August 2016

**E92-083029**
<table>
<thead>
<tr>
<th>Date</th>
<th>Grade/Age</th>
<th>Type of Exam</th>
<th>Significant Findings</th>
<th>Medical Provider</th>
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**RECORD:** Findings and Recommendations of Physicians including medications, operations and injuries; Modification of School Program; Referrals and Follow-up; Conference with Parents, Teachers; Counselling with Student. Individual Nurses notes must be attached.

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