SOMERSET COUNTY VOCATIONAL & TECHNICAL SCHOOLS

P.O. Box 6350 • 14 Vogt Drive • Bridgewater, NJ 08807-0350 • (908) 526-8900 • Fax: (908) 526-9212 • www.scvths.org

Diane M. Ziegler
Principal

Chrys Harttraft, Ed.D.
Superintendent of Schools

Application Deadline – March 1, 2019

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 nbasir@scvts.net

Sincerely,

Diane M. Ziegler

Diane M. Ziegler
Principal/Twilight Director

SOMERSET COUNTY VOCATIONAL & TECHNICAL HIGH SCHOOL

Post Office Box 6350
Phone: 908-526-8900 Ext. 7297

Bridgewater, NJ 08807
Fax: 908-252-3461

Office Use Only
Complete App. Rec'd:

APPLICATION FOR THE 2019 SUMMER TWILIGHT PROGRAM

STUDENT INFORMATION

Please Print

LAST NAME FIRST NAME MIDDLE NAME

HOME ADDRESS CITY STATE ZIP

DATE OF BIRTH GRADE MALE / FEMALE HOME PHONE NUMBER

* ( ) FATHER'S NAME DAYTIME PHONE # CELL PHONE #

* ( ) MOTHER'S NAME DAYTIME PHONE # CELL PHONE #

EMERGENCY CONTACT DAYTIME PHONE # RELATIONSHIP

PARENT E-MAIL ADDRESS SPECIAL DIETARY RESTRICTIONS

( ) 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 social/economic status. Contact Teresa Morelli, Title IX & Affirmative Action Officer, 908-526-8900. Ext. 7157.
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______________________________ ______________________
VICE PRINCIPAL'S SIGNATURE DATE

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______________________________ ______________________
DIRECTOR OF SPECIAL SERVICES SIGNATURE DATE

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/OR REPORT CARD _____ COPIES OF ALL STANDARIZED TEST SCORES

X____
COUNSELOR'S SIGNATURE DATE

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)

White	Black/African American	Asian	Hispanic/Latino	Native American	Other (please specify)

Household Annual Income:

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

Household Size	Annual Income Range
1	$13,500 and below
2	$13,501 - $18,000
3	$18,001 – $22,000
4	$22,001 – $26,000
5	$26,001 - $31,000
6	$31,001 - $36,000
7	$36,001 0 $40,000
8	$40,001 - $45,000
9 and over	Over $45,000

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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

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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.

SUMMER TWILIGHT

STATE OF NEW JERSEY
HEALTH HISTORY AND APPRAISAL

IMMUNIZATION REGISTRY NUMBER

Name of Child (Last, First, M.I.)	Date of Birth (Mo/Day/Yr)	Sex ☐ Male ☐ Female

PARENT OR GUARDIAN	NAME	TELEPHONE NO.
	ADDRESS	

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination *(If Td or DT, indicate in corner box)*					
Tdap					
POLIO – INACTIVATED POLIO VACCINE (IPV) *If oral vaccine, indicate (OPV) in corner box*					
MEASLES, MUMPS, RUBELLA (MMR)					
HAEMOPHILUS B (HIB)**					
HEPATITIS B					
VARICELLA					
PNEUMOCOCCAL CONJUGATE **					
MENINGOCOCCAL					
HEPATITIS A ***					
HPV (HUMAN PAPILLOMAVIRUS) ***					
OTHER					
OTHER					

LEAD SCREENING	
Test Date	**Result**

Document below single antigen vaccine receipt, serology titers, or varicella disease history

	Date:	Titer:
Hepatitis B	Date:	Titer:
Varicella	Date:	Titer:
Measles	Date:	Titer:
Mumps	Date:	Titer:
Rubella	Date:	Titer:

☐ Provisional admission attached–Date Granted:________________ ☐ Medical exemption attached ☐ Religious exemption attached

HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR
FOOD ALLERGIES		DIABETES		LYME DISEASE		JUVENILE RHEUMATOID ARTHRITIS	
NON-FOOD/NON-DRUG ALLERGIES		INFLUENZA (FLU)		MONONUCLEOSIS		AUTISM SPECTRUM DISORDERS	
		OTHER		NEUROMUSC. DISORDER		HEMATOLOGICAL DISORDERS	
ASTHMA		DRUG ALLERGIES		CHRONIC OTITIS MEDIA		ADD/ADHD	
CONGENITAL DISORDER		HEART DISEASE		AUTO IMMUNE DISORDERS		CONCUSSION/TBI	
CONVULSIVE DISORDER		HEPATITIS		STREP INFECTIONS			

HEALTH SCREENING CODE: N = Normal; R = Referred; T = Under Treatment; C = See Comments

Grade/Age																
Date																
Height																
Weight																
BMI***																
Blood Pressure																
VISION	With correction	R														
		L														
		BOTH														
	Without correction	R														
		L														
		BOTH														
	Muscle Balance															

Color Perception Date Results

HEARING																
Date																
Pure Tone	R															
	L															

BIENNIAL SCOLIOSIS SCREENING (Beginning at Age 10) Date____ Date____ Date____ Date____ Date____

Referred for abnormal result ☐ ☐ ☐ ☐ ☐

TB Screening (Mantoux or IGRA Test)	Date	Date	Chest X-Ray Date	Result Normal	Result Abnormal
Tested					
Read					
Mantoux Result (MM) or IGRA Result					

Medication
Reactor No Rx ☐
Date Started ________
Date Completed ________

**REQUIRED FOR DAY/CHILD CARE ENROLLEES (2 Months-5th Birthday Only) ***Not Required

SUMMER TWILIGHT

PHYSICAL EXAMINATIONS

Date	Grade/Age	Type of Exam	Significant Findings	Medical Provider

Date	RECORD: Findings and Recommendations of Physicians including medications, operations and injuries; Modification of School Program; Referrals and Follow-up; Conference with Parents, Teachers; Counseling with Student. Individual Nurses notes must be attached.	SIGNATURE