

**Haddon Heights Preschool Disabled Program with  
Opportunity of Inclusion for Typically Developing Students**

Child's Name:	
Birth Date:	Gender:
Address: (Street, City, State, Zip)	
Home Phone:	Cell Phone:
Parent/Guardian: (Please Print Name)	
<input type="checkbox"/> I am interested in enrolling my child in the preschool inclusion class for the 2019-2020 school-year. I understand this program is 2 hours and 25 minutes, 5 day per week.	
<input type="checkbox"/> I am interested in reenrolling my child in the preschool inclusion class for the 2019-2020 school-year. I understand this program is 2 hours and 25 minutes, 5 day per week.	
My signature below indicates an understanding of and my agreement with the terms on the information and application page.	
Parent/Guardian Signature:	

**Lotteries will be held on the date listed on the district website, to determine entry into the program. A lottery will be held for residents in each age group. If spots remain after the resident lottery is complete, a separate lottery will be held for non-resident staff to fill the remaining open spots.**

Mail or return completed application to:

Haddon Heights School District, Child Study Team Office  
316-B Seventh Avenue  
Haddon Heights, NJ 08035