

Haddon Heights Student Residency Questionnaire

Name of School _____

Name of Student: _____ Sex: Male
Last First Middle Female

Birth Date ____/____/____ Age: ____
Month / Day / Year

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C. 11435. The answers to this residency information help determine the services the student may be eligible to receive.

1. Is your current address a temporary living arrangement? ____ Yes ____ No
2. Is this temporary living arrangement due to loss of housing or economic hardship?
____ Yes ____ No

**If you answered YES to the above questions, please complete the remainder of this form.
If you answered NO, you may stop here.**

Where is the student presently living? (Check one box.)

- In a motel
- In a shelter
- With more than one family in a house or apartment
- Moving from place to place
- In a place not designed for ordinary sleeping accommodations such as a car, park, or campsite

Name of Parent(s)/Legal Guardians(s): _____

Last Permanent Residence: _____

Date of displacement: _____

Current Address: _____ Zip _____ Phone _____

Presenting a false record or falsifying records is an offense under Section 37.10, Penal code, and enrollment of the child under false documents subjects the person to liability for tuition or other costs. TEC Sec. 25.002(3)(d).

Signature of Parent/Legal Guardian _____ Date _____

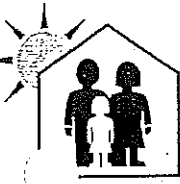
Please send a copy to Jocqueline Renner, Homeless Liaison, at the Child Study Team Office.

Fax: 856-546-3774

I certify the above named student qualifies for the Child Nutrition Program under the provisions of the McKinney-Vento Act.

Date

McKinney-Vento Liaison Signature



GLOUCESTER COUNTY SPECIAL SERVICES SCHOOL DISTRICT

1340 TANYARD ROAD • SEWELL, NJ 08080
 TELEPHONE: (856) 468-6530 x1053 • FAX: (856) 468-0851

McKINNEY-VENTO EDUCATION PROGRAM

This is to verify that, for as long as my child(ren) is/are eligible for Gloucester County Special Services School District McKinney Education Program services, I give permission to the Gloucester County Special Services School District McKinney Education staff or representative to provide supplemental tutoring, and health and supportive services to my child(ren), and to transport them for those services, if necessary:

Name	Gender	Date of Birth	School ID Number (SID)	School	Grade

I am willing to assume full responsibility for my child(ren)'s safety in connection with McKinney Education-funded or related activities.

I also hereby authorize the public or private school district as well as vision, health and dental service providers to release to the Gloucester County Special Services School District McKinney Program all records relating to my child(ren), including academic, medical and/or Child Study Team information.

Signature of Parent/Guardian

Date

Parent's/Guardian's Names: _____

Present Address: _____

Present Phone Number: _____

School District: _____