

SPENCER COUNTY SCHOOLDISTRICT
Agenda Item

Item # _____ Meeting Date 9/26/2016

Topic/Title Shortened School Day/SCHS Student #2

Presenter _____

Origin

____ Topic presented for information only (*no board action required*).

____ Action requested at this meeting.

X Item is on the consent agenda for approval.

____ Action requested at future meeting, _____ (date).

X Board review required by –

X State or federal law or regulation

 ____ Board of Education policy

 ____ Other _____

Previous Review, Discussion or Action

X No previous Board review, discussion or action

____ Previous review or action

 Date _____

 Action _____

Background/Summary of Information:

Impact on Resources (REQUIRES FINANCE OFFICER'S INITIALS OF REVIEW).

 Finance Officer

Timetable for Review or Action.

SUPERINTENDENT'S RECOMMENDATION

Recommend approval as presented.

Kentucky Department of Education
Division of Learning Services Services
NOTICE OF SHORTENED SCHOOL DAY and/or WEEK 2016-2017

Date of Request: 8/30/16

Special Education Cooperative	Ohio Valley Educational Cooperative		
District:	Spencer County Schools	District Number:	541
Director of Special Education:	Todd Russell	Phone Number:	502-477-6787
School:	Spencer County High School		
Principal:	Curt Haun		

Student Information			
Full Name:	[REDACTED]	Disability:	[REDACTED]
Age:	[REDACTED]	SSID:	[REDACTED]

Teacher Information			
Full Name:	Amanda Bruce	Grade Taught:	9 through 14
Classroom Type:	Resource Room		
Special Education Code:	6010		

Type of Request (Check all that apply):

☐ Shortened Week ☒ Shortened Day

Shortened School Week (SWD):

1a. Check the days of attendance for this student according to their current IEP?

<input type="checkbox"/>	Monday	<input type="checkbox"/>	Tuesday	<input type="checkbox"/>	Wednesday	<input type="checkbox"/>	Thursday	<input type="checkbox"/>	Friday
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1b. Describe the reason(s) why this student requires a **Shortened School Week**:

N/A

1c. Provide the typical beginning and ending time for students in this school?

BEGINNING TIME:

ENDING TIME:

1d. Provide the beginning and ending times for this student according to current IEP?

BEGINNING TIME:

ENDING TIME:

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Notice of Shortened School Day / Week

2015-2016 Rev 09/10/2015

Shortened School Day (SSD):

2a. Describe the reason(s) why this student requires a **Shortened School Day**:

The student is in grade 14 and is transitioning to a day program for this school year. He is supposed to be attending the day program in the afternoon each school day.

2b. Provide the typical beginning and ending time for students in this school?

BEGINNING TIME: 7:40am

ENDING TIME: 11:30am

2c. Provide the beginning and ending times for this student according to current IEP?

BEGINNING TIME: 7:40am

ENDING TIME: 11:30am

3. Is this student returning to school after being in a Home/Hospital Instruction Program?

☐ Yes

☒ No

If yes, describe circumstances:

N/A

4. Identify steps the ARC will take to promote full attendance for this student in the future?

The student is in grade 14 and will transition to the day program full-time next school year.

5. Has a shortened school day been requested for this student in previous school years?

☒ Yes

☐ No

If yes, list the previous school year(s):

SWD: 2015-2016

6. Is there a signed Physician statement:

☐ Yes

☒ No

IMPORTANT

The district must maintain the following documentation for all Shortened School Days approved by the Local Board of Education:

- Approval by the Local Board of Education (**STUDENT CONFIDENTIALITY** procedures **MUST** be followed when listing student information in the Local Board Minutes.);
- Minutes of the ARC meeting documenting the ARC decision that a shortened school day is needed;

- A copy of the student's IEP documenting the shortened school day; and ☐ A copy of the Physician statement of the medical need.
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FOR LOCAL USE ONLY

LOCAL BOE APPROVED: ☐ Yes ☐ No DATE: _____

FOR KDE USE ONLY

WAIVER NO.: _____ DATE: _____

RECEIVED AT KDE: _____ DATE: _____

(Reviewer's Initials)