

**SPENCER COUNTY SCHOOLDISTRICT**  
**Agenda Item**

Item # \_\_\_\_\_ Meeting Date 9/26/2016

Topic/Title Shortened School Week/SCHS Student

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:** 9/15/16

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:	6122 - FMD Resource/Itinerant		

**Type of Request** (Check all that apply):

☒ Shortened Week    ☐ Shortened Day

**Shortened School Week (SWD):**

1a. What are the days of attendance for this student according to current IEP?

Tuesday and Friday
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1b. Describe the reason(s) why this student requires a **Shortened School Week**:

The student receives 5 hours of in home therapy on Monday, Wednesday, and Thursday each day.
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1c. Provide the typical beginning and ending time for students in this school?

BEGINNING TIME: 7:40am                      ENDING TIME: 2:30pm

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

BEGINNING TIME: 7:40am                      ENDING TIME: 2:30pm

**Shortened School Day (SSD):**

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

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

BEGINNING TIME:

ENDING TIME:

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

BEGINNING TIME:

ENDING TIME:

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

☐

Yes

☒

No

If yes, describe circumstances:

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

As the student lessons the need for the in home therapy, participation in the school environment will increase.

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):

6. Is there a signed Physician statement:

☒

Yes

☐

No

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**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:

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**FOR KDE USE ONLY**

WAIVER NO.:

\_\_\_\_\_

DATE:

\_\_\_\_\_

RECEIVED AT KDE:

\_\_\_\_\_

DATE:

\_\_\_\_\_

(Reviewer's Initials)