



FLOYD COUNTY BOARD OF EDUCATION  
Tonya Horne-Williams, Superintendent  
442 KY RT 550  
Eastern, KY 41622  
Telephone (606) 886-2354 Fax (606) 886-4550  
www.floyd.kyschools.us

William Newsome, Jr., Board Chair - District 3  
Linda C. Gearheart, Vice-Chair - District 1  
Dr. Chandra Varia, Member- District 2  
Keith Smallwood, Member - District 4  
Steve Slone, Member - District 5

**Consent Agenda Item (Action Item):**

Approve the submission of notice to KDE for Students with Disabilities who require a shortened school day or school week based upon their IEP and physician recommendation for the 2024-2025 school year.

**Applicable State or Regulations:**

707 KAR 1:320 Individual Education Program (Statutory Authority: KRS 156.070, 156.060, 157.220 and 167.015)

**Fiscal/Budgetary Impact:**

None

**History/Background:**

Each Admissions and Release Committee (ARC) shall ensure that the length of the instructional / school day for each child or youth with a disability is the same as for children without disabilities except as specified in an Individual Education Plan (IEP) or 504 plan. An ARC may determine that the length of the school day can be changed for a child or youth if the medical condition (provided by the physician) of the child or youth indicates that the instructional day or week needs to be altered based upon written evidence. The local education agency shall submit request for shortened school day to the local Board of Education for approval prior to notification to the Kentucky Department of Education. Board action shall be subject to confidential requirements. Admissions and Release Committees at Prestonsburg Elementary, Allen Elementary School, May Valley Elementary, Duff Allen Central Elementary and South Floyd Elementary have addressed recommendations involving a shortened school day / week for students enrolled at these schools.

**Recommended Action:**

The Floyd County Board of Education approves a shortened school day / week for a student with special needs as specified in the student's respective IEP or 504 plans as recommended by the Admissions and Release Committee.

**Contact Person(s):**

Cinda Francis, Chief of Special Education 606.886.2354

N/A  
Principal

Cinda Francis  
Director

Tonya H. Williams  
Superintendent

**Date:**

2-3-2025



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**LENGTH OF SCHOOL DAY/WEEK - PHYSICIAN'S STATEMENT**

Evidence must be submitted from a physician and an Admissions and Release Committee in order to determine approval or disapproval for waivers related to length of school day/week. The information described below is to be provided to the ARC by the physician of the child or youth in order to assist in making determination.

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

1. A statement that specifies why a shortened school day/week is required
  - a. Describing the medical condition of the child or youth and
  - b. Describing the impact of the medical condition on the ability of the child or youth to participate in a full instructional day/week.

*suffers from Social & Generalized anxiety & he has LD in Reading. He has been attending school regularly, gets all his school assignments completed in the first half of school. He gets highly*

2. The anticipated duration of the need for an altered length of school day/week

*will benefit from attending school 8 am until noon Monday through Friday, beginning of the school year until the end of the school year 2024 to 2025. Numerous irritations at times.*

3. Any harmful effects on the child or youth if the length of the school day/week is not altered

*has difficulties socializing with peers due to having persistent anxiety. It has affected his emotional well being & lead to him becoming bored, agitated & inactive at times. Efforts to improve his social skills have been ineffective as of now.*

Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_

Physician's Name -- Printed or Typed \_\_\_\_\_

Telephone Number \_\_\_\_\_

Physician's Mailing Address: \_\_\_\_\_

Street or Post Office Box \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

MANMOHAN P. POTHULOORI, M.D.  
DEA #BP2140516  
LIC #43327



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diagnosed - Autism Spectrum disorder. He  
 currently attends via therapy 3 days/week for a  
 total of 9 hrs/week Tues, wed, Thurs from 1:00-5:00

2. The anticipated duration of the need for an altered length of school day/week

2024-2025 school year

3. Any harmful effects on the child or youth if the length of the school day/week is not altered

if the day is not altered, he will not be able to  
 attend schools which have been an important part in  
 his education to ensure an appropriate education.

Physician's Signature \_\_\_\_\_

9/3/24

Date

Physician's Name - Printed or Typed \_\_\_\_\_

(606) 372-1239

Telephone Number

Physician's Mailing Address: 713 Broadway St Suite 203

Paintsville

KY

Street or Post Office Box

41240

City

State

Zip Code

Admin - Signed Forms & Letters for  
E#28546

09/06/2024 THU 12:16 FAX --- Athens Wayland RHC

001/001



FLOYD COUNTY BOARD OF  
EDUCATION  
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440 KY RT 836  
Buckhorn, KY 41601  
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Autism Dx - Becomes agitated due to overcrowding and noise stimulation. He can not sit still, constantly fidgeting, and exhibiting a negative attitude w/ school.

2. The anticipated duration of the need for an altered length of school day/week

Pick up 2:30 everyday, Tuesday - OT 9-10 AM  
Behavior Therapy X 1 month times vary

3. Any harmful effects on the child or youth if the length of the school day/week is not altered

Could regress in areas that have improved developmentally.

Physician's Signature: \_\_\_\_\_ Date: (11/06) 5/21-4040

Physician's Name - Printed or Typed: \_\_\_\_\_ Telephone Number

Physician's Mailing Address: Compassion Pediatrics of  
Wayland LLC  
Wayland, KY 41601

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_



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  - b. Describing the impact of the medical condition on the ability of the child or youth to participate in a full instructional day/week.

Autism; He is easily overstimulated, has difficulty sleeping at night, sometimes has a difficult time in the mornings

2. The anticipated duration of the need for an altered length of school day/week

Monday, Tuesday, Thursday : Friday 9am to 2pm  
Wednesday 8:15am to 2:30pm

3. Any harmful effects on the child or youth if the length of the school day/week is not altered

This schedule will prevent him from getting overstimulated, prevent behavior from worsening and prevent a delay in progress.

Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_

Physician's Name - Printed or Typed \_\_\_\_\_

Telephone Number \_\_\_\_\_

Physician's Mailing Address: 400 University Dr

Prestonsburg  
City

Ky  
State

Street or Post Office Box

411653  
Zip Code



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has anxiety, expressive language disorder, depression  
Right arm paralysis gets anxious and overwhelmed  
and will shortened day and week to adjust and progress.

2. The anticipated duration of the need for an altered length of school day/week

1 year 9:00 - 11:30

3. Any harmful effects on the child or youth if the length of the school day/week is not altered

needs shortened day and week to adjust due to  
his medical diagnosis to prevent anxiety and  
regression.

Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_

Physician's Name – Printed or Typed \_\_\_\_\_

Megan Tackett, APRN  
 Big Sandy Community Health Center  
 246 KY Rt 979  
 Harold, KY 41635

Telephone Number \_\_\_\_\_

Physician's Mailing Address: \_\_\_\_\_

606-478-2200  
 Street or Post Office Box \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_



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  - b. Describing the impact of the medical condition on the ability of the child or youth to participate in a full instructional day/week.

\_\_\_\_\_ is Autistic, struggles with meltdowns and not listening to Teachers if the days are not shortened.

2. The anticipated duration of the need for an altered length of school day/week

For the 24-25 school year

3. Any harmful effects on the child or youth if the length of the school day/week is not altered

she will be detrimental on \_\_\_\_\_ as she is prone to having more meltdowns if not.

Her school days will be as follows: M, W, F, Full days  
 Tu, Th, shortened (8am-12pm)

Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_

Physician's Name – Printed or Typed \_\_\_\_\_

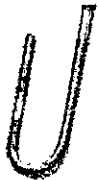
Telephone Number \_\_\_\_\_

Physician's Mailing Address: 400 University Dr \_\_\_\_\_  
Street or Post Office Box

Prestonsburg  
City

KY  
State

41653  
Zip Code



To:

Fax

Page: 4 of 5

01/09/2024 2:13 PM



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Autism

ADHD

2. The anticipated duration of the need for an altered length of school day/week

1 year - school schedule, begin with 2-3 days per week from 9:00 to 12:00pm, gradually increasing as tolerated by student.

3. Any harmful effects on the child or youth if the length of the school day/week is not altered

Worsening behaviors increased irritability

Physician's Signature

Date

Physician's Name -- Printed or Typed

Telephone Number

Physician's Mailing Address:

Street or Post Office Box

City

Eastern Ky Tender Care Pediatrics  
400 University Drive  
Prestonsburg, KY 41653  
P: 606-886-1173  
F: 606-886-2193

Zip Code





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Autism

Behavior impedes his learning and learning of others

2. The anticipated duration of the need for an altered length of school day/week

Monday - Thursday 11:30am - 2:30pm due to therapies in mornings  
No school days on Friday to not disrupt routine

3. Any harmful effects on the child or youth if the length of the school day/week is not altered

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_

Physician's Name - Printed or Typed \_\_\_\_\_

Telephone Number \_\_\_\_\_

Physician's Mailing Address: \_\_\_\_\_

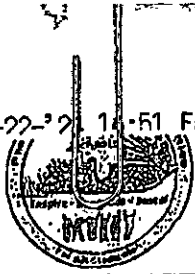
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is a former premature infant. has multiple  
Developmental issues that require multiple appointments  
from different doctors. has outside therapy appointments

2. The anticipated duration of the need for an altered length of school day/week

This will need to continue throughout the year  
Tuesdays

3. Any harmful effects on the child or youth if the length of the school day/week is not altered

The child needs to be able to complete work  
as needed when absent from school. The child does  
not need to be punished for attending appointments.  
Missed class appointments would be detrimental to her health.

X \_\_\_\_\_  
Physician's Signature

01/22/24  
Date

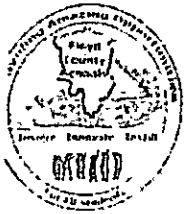
\_\_\_\_\_  
Physician's Name - Printed or Typed

1  
\_\_\_\_\_  
Telephone Number

Physician's Mailing Address: \_\_\_\_\_

Pikeville \_\_\_\_\_  
City State Zip Code

KY 41501  
Street or Post Office Box State Zip Code



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Autism  
 has trouble focusing for long periods

2. The anticipated duration of the need for an altered length of school day/week

ABA therapy Monday - Thursday 1:30 - 5:00  
 at Frontier Behavioral Health - leave school at 1:00

3. Any harmful effects on the child or youth if the length of the school day/week is not altered

worsening behavior  
 Increased aggression

\_\_\_\_\_, Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_, Physician's Name - Printed or Typed \_\_\_\_\_ Telephone Number \_\_\_\_\_

Physician's Mailing Address: 400 University Dr  
Prestonsburg Ky 41653  
 City State Zip Code



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442 KY RT 550

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Speech Apraxia

2. The anticipated duration of the need for an altered length of school day/week

Will leave on Tuesdays at 12:00 for speech and OT Services at McDowell ARH

3. Any harmful effects on the child or youth if the length of the school day/week is not altered

Delayed Speech Development

Physician's Signature

Date

Physician's Name – Printed or Typed

Telephone Number

Physician's Mailing Address:

400 University Dr  
Prestonsburg Ky 41653



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Autism - Fatigue

2. The anticipated duration of the need for an altered length of school day/week

Monday through Friday 8am - 12:30pm

3. Any harmful effects on the child or youth if the length of the school day/week is not altered

worsening behavior, delay in progress

Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_

Physician's Name - Printed or Typed \_\_\_\_\_

Telephone Number \_\_\_\_\_

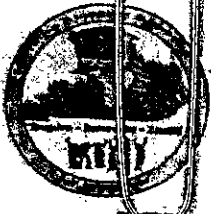
Physician's Mailing Address: \_\_\_\_\_  
Eastern Ky Tender Care Pediatrics  
400 University Drive, STE 101  
Prestonsburg, KY 41659 or Post Office Box

P: 606-886-1173  
F: 606-886-2193

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_



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*Acute non-verbal autism. The impact would be excessive fatigue leading to increased self-harm, which would cause safety concerns for the child & possible regression of gains made in school.*

2. The anticipated duration of the need for an altered length of school day/week

*Monday - Thursday until 12:45pm  
Friday until 3pm or end of school day.*

3. Any harmful effects on the child or youth if the length of the school day/week is not altered.

*+ increase in self-harm (head-hitting)  
+ fatigue leading to irritability  
+ possible regression due to fatigue/emotional stress*

Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_

Telephone Number \_\_\_\_\_

Physician's Name - Printed or Typed \_\_\_\_\_

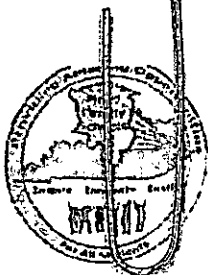
Physician's Mailing Address \_\_\_\_\_

Street or Post Office Box \_\_\_\_\_

City \_\_\_\_\_

Zip Code \_\_\_\_\_

Eastern KY Tender Care Pediatrics  
400 University Drive, Ste 101  
Prestonsburg, KY 41653  
P: 606-886-1173  
F: 606-886-2193



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Autism - Attends AVA Center for therapy

2. The anticipated duration of the need for an altered length of school day/week

Tuesday & Thursday 8am - 12:45pm  
 Monday, Wednesday, Friday normal schedule

3. Any harmful effects on the child or youth if the length of the school day/week is not altered

worsening behavior  
 delay in progress

Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_

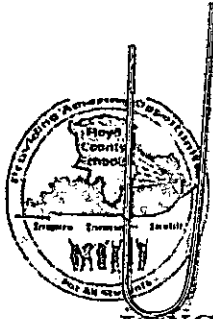
Physician's Name - Printed or Typed \_\_\_\_\_

Telephone Number \_\_\_\_\_

Physician's Mailing Address: \_\_\_\_\_

Prestonsburg City Ky State Street or Post Office Box 41653 Zip Code

Eastern Ky Tender Care Pediatrics  
 400 University Drive, STE 101  
 Prestonsburg, KY 41653  
 P: 606-886-1173  
 F: 606-886-2193



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Down Syndrome

2. The anticipated duration of the need for an altered length of school day/week

5 days a week, will attend 8:00-12:00 noon  
daily

3. Any harmful effects on the child or youth if the length of the school day/week is not altered

patient has therapy Appts. daily.

Physician's Signature

Date

Physician's Name – Printed or Typed

Telephone Number

Physician's Mailing Address:

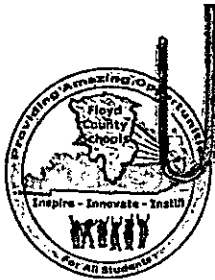
400 University Dr.  
Prestonsburg.  
City

Street or Post Office Box

Ky  
State

41623  
Zip Code





FLOYD COUNTY BOARD OF EDUCATION  
Office of Superintendent  
442 KY RT 550  
Eastern, KY 41622  
Telephone (606) 886-2354 Fax (606) 886-4550  
www.floyd.kyschools.us

### LENGTH OF SCHOOL DAY/WEEK – PHYSICIAN’S STATEMENT

Evidence must be submitted from a physician and an Admissions and Release Committee in order to determine approval or disapproval for waivers related to length of school day/week. The information described below is to be provided to the ARC by the physician of the child or youth in order to assist in making determination.

Student Name: \_\_\_\_\_ Date of Birth: 11/29/19

1. A statement that specifies why a shortened school day/week is required
  - a. Describing the medical condition of the child or youth and
  - b. Describing the impact of the medical condition on the ability of the child or youth to participate in a full instructional day/week.

Autism - requires ABA therapy, recommended by physician

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2. The anticipated duration of the need for an altered length of school day/week

2 days - Monday and Friday

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3. Any harmful effects on the child or youth if the length of the school day/week is not altered

decrease in everyday function

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---

Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_

Physician's Name - Printed or Typed \_\_\_\_\_

Telephone Number \_\_\_\_\_

Physician's Mailing Address: \_\_\_\_\_

Street or Post Office Box \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_



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LENGTH OF SCHOOL DAY/WEEK - PHYSICIAN'S STATEMENT

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Autism

2. The anticipated duration of the need for an altered length of school day/week

Monday - Friday 8am - 1:00 pm  
2024-2025 School year

3. Any harmful effects on the child or youth if the length of the school day/week is not altered

Regression, Aggression

Physician's Signature

Date

Physician's Name - Printed or Typed

Telephone Number

Physician's Mailing Address:

Street or Post Office Box

City

State

Zip Code

Eastern Ky Tender Care Pediatrics  
400 University Drive, STE 101  
Prestonsburg, KY 41653  
P: 606-886-1173  
F: 606-886-2193

Aug. 14. 2024 8:3AM

Tender

No. 8012 P. 1/1



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### LENGTH OF SCHOOL DAY/WEEK - PHYSICIAN'S STATEMENT

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Date of Birth: \_\_\_\_\_

1. A statement that specifies why a shortened school day/week is required
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  - b. Describing the impact of the medical condition on the ability of the child or youth to participate in a full instructional day/week.

Autism Spectrum disorder, Shortened days are needed to decrease anxiety & frustration

2. The anticipated duration of the need for an altered length of school day/week

All school year, PT has speech, OT, & PT @ 2pm on Monday. Regular schedule Tues-Friday.

3. Any harmful effects on the child or youth if the length of the school day/week is not altered

PT will not get recommended therapy needed to improve his dx.

Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_

Physician's Name - Printed or Typed \_\_\_\_\_

Telephone Number \_\_\_\_\_

Physician's Mailing Address: \_\_\_\_\_

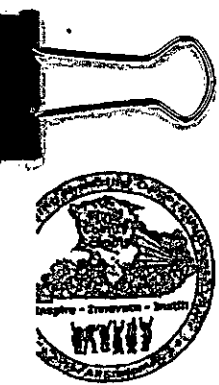
Street or Post Office Box \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

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  - b. Describing the impact of the medical condition on the ability of the child or youth to participate in a full instructional day/week.

Autism

Receives therapy at AVA Center 1:15-5:40 on  
Tuesday & Thursday

2. The anticipated duration of the need for an altered length of school day/week

Monday, Wednesday & Friday Regular Schedule.  
Tuesday and Thursday 8am to 12:30pm

3. Any harmful effects on the child or youth if the length of the school day/week is not altered

Worsening behavior, delay in progress

Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_

Physician's Name - Printed or Typed \_\_\_\_\_

Telephone Number \_\_\_\_\_

Physician's Mailing Address: \_\_\_\_\_

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400 University Drive, Suite III  
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