# REDUCED SCHEDULE APPROVAL FORM

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| **School District** |  | **School Year** |  |
| **Building** |  | [ ]  **Fall**  | [ ]  **Supplemental** |
| **Pupil’s Name** |  | **Birthdate** |  |
| **Date Completed** |  | **Grade** |  |

The above-named pupil’s educational needs are best served by a reduced schedule (minimum of 879 hours in accordance with Section 101 of the State Aid Act.)

The following documents are attached:

|  |  |
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| [ ]  | Pupil/Parent/Guardian request for reduced schedule |
| [ ]  | Counselor or Authorized District Representative evaluation indicating that a reduced schedule best serves this pupil’s educational needs |
| [ ]  | If special education pupil on reduced IEP, note from licensed physician  |

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Permission for a reduced schedule has been granted for the following reason(s):

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| [ ]   | Economic necessity: |  |
|  |
| [ ]   | Family reasons: |  |
|  |
| [ ]   | Other (describe): |  |
|  |

The pupil understands that failure to perform satisfactorily under a reduced schedule will cancel this special consideration, and he/she will be required to return to a full schedule.

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| **Pupil** | **Counselor/Authorized District Representative** |
|  |  |
| **Parent, (if pupil under 18)** | **Principal** |