**FORM A- Reduced timetable implementation form**

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| **Student Name:** |  | **DOB:** |  |
| **School Roll/ Alternative Provider Name:** |  | **Year Group:** |  |
| **Date reduced timetable commences:** |  | **Review Date (1st review within 4 weeks):** |  |

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| **Rationale for reduced timetable?****What are the barriers to the student not accessing full time education?****Is this evidenced in Multi Agency reviews? YES/NO Date of last review:****What are the risk factors to the student not accessing full time education? Attach completed risk assessment****What are the steps to full time education and the date a return is planned? Attach a completed action plan****Does the student have an EHCP/ Statement? YES/NO****(If YES advice must be sought from ICDS)****Is this a Child Looked After? YES/NO****If YES advice must be sought from Virtual School)** |

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| **Student views:** |

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| **Parent/ Carer views:** |

**Advice sought from supporting professionals (e.g. ICDS, EPS, PSED, SFSS, Early Help services, Children’s Social Care, Health, Fair Access):**

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| **Name/ Agency** | **Contact details** | **Advice sought (including date)** |
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**Planned Provision- where will the student be learning, with whom and what work will be sent home. Include hours of provision and sessions with no planned supervised education (i.e. when a pupil is at home doing school work):**

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|  | **am** | **Lunchtime** | **pm** | **Total teaching hours** |
| **Monday** |  |  |  |  |
| **Tuesday** |  |  |  |  |
| **Wednesday** |  |  |  |  |
| **Thursday**  |  |  |  |  |
| **Friday** |  |  |  |  |
|  |  |  | **Weekly Total** |  |

**Agreed objectives of the reduced timetable:**

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| **Named senior member of staff in school:** | **Contact details:** |
| **Date:** | **Signed:** |

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| **Parent/ Carer name:** | **Contact details:** |
| **In agreeing to a reduced timetable I understand that my child’s attendance will be marked as ‘authorised absence’ for the sessions it is agreed that he/she/they will not be required in school. During these sessions I confirm that I will be responsible for his/her/their safety and wellbeing.** |
| **Date:** | **Signed:** |

**ACTION PLAN TO SUPPORT RE-INTEGRATION TO FULL TIME EDUCATION, to include actions agreed by supporting professionals e.g. ICDS, EPS, PSED, SFSS, Early Help services, Children’s Social Care, Health, Fair Access**

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| **WHO?** | **OBJECTIVE THIS IS WORKING TOWARDS?** | **ACTION?** | **BY WHEN?** | **IMPACT? (this section will be completed at review)** |
| **SCHOOL****Named person:** | 1.2.3. | 1.2.3. |  |  |
| **STUDENT****Name:** | 1.2.3. | 1.2.3. |  |  |
| **PARENT/ CARER****Name:** | 1.2.3. | 1.2.3. |  |  |
| **OTHER****Name:** |  |  |  |  |
| **OTHER****Name:** |  |  |  |  |
| **OTHER****Name:** |  |  |  |  |