



SHORT-TERM INDEPENDENT STUDY REQUEST

Short-Term Independent Study Policies

Please submit this form to request short-term (max: 14 days, min: 5 days) independent study. Requests must be submitted at least ten (10) days prior to the absence.

Student Full Name: _____ Student ID#: _____
Student Age: _____ Date of Birth: _____
Parent Name: _____ Parent Email: _____

Additional Information you would like to provide regarding your request:

School Site	Grade Level	Additional Information
<input type="checkbox"/> Jefferson School	<input type="checkbox"/> TK	<input type="checkbox"/> Student has a 504 Plan
<input type="checkbox"/> Tom Hawkins School	<input type="checkbox"/> K	<input type="checkbox"/> Student has an IEP
<input type="checkbox"/> Monticello School	<input type="checkbox"/> 1st	<input type="checkbox"/> Student is an EL Student
<input type="checkbox"/> Anthony Traina School	<input type="checkbox"/> 2nd	<input type="checkbox"/> None of the above apply
<input type="checkbox"/> Corral Hollow School	<input type="checkbox"/> 3rd	
	<input type="checkbox"/> 4th	
	<input type="checkbox"/> 5th	
	<input type="checkbox"/> 6th	
	<input type="checkbox"/> 7th	
	<input type="checkbox"/> 8th	

Reason for Independent Study Request:

☐ Family Emergency – Non-Local
☐ Family Emergency - Local
☐ Personal/Social Student Needs
☐ Health or Medical Related
☐ Vacation Travel

First day of Independent Study: _____
Last day of Independent Study: _____
Date student returning to school: _____

- ☐ I understand all independent study work is due on the day the student returns to school.
- ☐ I understand if a student does not return on the day they are scheduled to return, absences past the return date will be unexcused and the student will be ineligible for future independent study contracts. Student may lose their place in their assigned school/courses if they do not return as scheduled.
- ☐ I understand students/caregivers should reach out to their assigned teachers if they have any questions regarding assignments.
- ☐ I understand after submitting this form the school site will reach out to let you know if the request has been approved. Upon approval, parents/guardians and the student must sign the Independent Study Master Agreement. Independent Study Master Agreements must be signed/approved prior to the beginning of Independent Study.

Student Signature

Date

Parent/Guardian Signature

Date



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SUBJECT	TEACHER	INITIAL	ADA CREDIT
P.E.			
HISTORY			
SCIENCE			
READING			
L.A.			
MATH			



APPROVED



DENIED



Minimum 5 days requirement not met



Maximum 14 days requirement exceeded



Office/Administrator not notified 10 days prior to absence



Student grades below standard grade level



Student referred to SART/SARB, not eligible



Exceeds 6 requests from grades K-12



Incomplete prior Independent-study plans



Falls within first 20 school days (Not subject to Appeal)



Falls within last 20 school days (Not subject to Appeal)

Name

Date

Signature

Appeal Section Only

Appeals must be submitted within ten (10) school days from date denial was received.

Student Full Name: _____

Student ID#: _____

Parent/Guardian Name: _____

Date: _____

Appeal requested for the following reasons:

Student Signature

Date

Parent/Guardian Signature

Date

JEFFERSON ELEMENTARY SCHOOL DISTRICT



APPEAL APPROVED



APPEAL DENIED

Reason: _____

Superintendent Signature

Superintendent Name

Date

1219 Whispering Wind Drive, Tracy, CA 95377 (209) 836-3388