STUDENT RE-ENTRY PLAN CHECKLIST

Student Name: ______________________ **ID:** ____________ **Grade:** ______

School Name: ______________________ **Meeting Date:** ______________

Length of time student has been out of school: ____________

Date returning: ____________

Last school attended: ______________________

CYFD custody? ☐ **Yes** ☐ **No**

If Yes, BID completed? ☐ **Yes** ☐ **No**

If BID not complete, contact Foster Care Point of Contact Manager: *Stephanie.browne@aps.edu or 855-9843*

1. Request **transcripts** if student received education at a treatment facility:

   Date requested: ____________ Date received: ____________

2. Determine applicable **accommodations**:

Accommodation Type	Date of Current Plan or Date Review Scheduled	Person Responsible for Updating and Distributing as Needed	Comments
SPED – IEP			
SAT Process			
504			
Health Plan / Discuss Meds with Nurse			
BIP			

3. Does student need a **modified schedule** or **school day?** ☐ **Yes** ☐ **No**
   If yes, modifications made **and** person responsible:

4. Does student have **missing assignments** or **class work**? **(**If ***yes***, use attached work sheet) ☐ **Yes** ☐ **No**
5. **Release of Information** from health provider to address medical and academic needs? ☐ **Yes** ☐ **No**
6. **Outpatient follow up** scheduled? ☐ **Yes** ☐ **No**
   If yes, Name of outpatient provider: ______________________ Date scheduled: ____________
   If no, referring to: ______________________
7. Identify a school staff member **check in with student regularly** and update Re-Entry Plan as needed:
   Name of identified staff member: ______________________
8. **Additional information from facility** regarding student's diagnosis, behavior, and recommended school interventions to support success:

9. **Additional information from family and student** regarding hospitalization or concerns about re-entry process:

10. **Student Re-Entry Action Plan for Teachers** distributed *(page 3 only)*:
    Name of staff member responsible: ______________________ **and** Date staff notified: ____________

STUDENT RE-ENTRY PLAN CHECKLIST

The following individuals participated in developing the transition plan for the student named above:

Name	Signature	Role

Suggested role groups to include as appropriate:

Student
Parent/Guardian(s)
Treatment facility representative(s)
School Counselor
School Nurse (or Behavioral Health Resource Nurse)
Administrator
SPED teacher
Social Worker
Crossroads Counselor
School-based Therapist
Teacher
Community Provider

☐ ***Copy of Re-Entry Plan sent to Behavioral Health Resource Nurse, City Center 385W via intra-office mail or to eve.wohlert@aps.edu for data tracking purposes.***

STUDENT RE-ENTRY PLAN CHECKLIST

Student Re-Entry Action Plan for Teachers

___________________________ is returning to school on _______________ after an extended absence.
(Student name) (Date)

The following considerations will support the student's re-entry:

- Student is permitted access to:
  ☐ Counselor
  ☐ Nurse
  ☐ Office
  ☐ Other ______________________
- Student has a modified schedule or school day as follows: ☐ N/A

- The following accommodations have been updated or are scheduled for review: ☐ N/A

- Student needs plan for missed work and an opportunity to make up assignments (may use table below): ☐ N/A

Course	***Teacher***	***Missed assignment(s)***	***Assignment forgiven*** *or* ***Plan for make-up work***