

**Notification of a Temporary Part-Time Timetable**

Please complete a separate form for each child who is on a part-time timetable (PTT), prior to the start

**Pupil Details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| UPN |  |  | Gender |  |
|  |  |  |
| Forename |  |  | DoB (dd/mm/yyyy) |  |
|  |  |  |
| Middle name(s) |  |  | NCY |  |
|  |  |  |
| Surname |  |  | Free School Meals |  |
|  |  |  |
| SEN Stage |  |  | Care Status |  |

**School Details**

|  |  |  |  |
| --- | --- | --- | --- |
| DfE |  | School Name |  |

|  |
| --- |
| Details of any offsite/alternative provision included in the part-time timetable |
|  |

**Temporary Part-Time Timetable Details**

|  |  |
| --- | --- |
| Number of hours per week? |  |
|  |
| Principal Reason |  |
|  |
| Date PTT started (dd/mm/yyyy) |  |
|  |
| Planned date to return to full-time education |  |

If there is at this point, no planned return date, please provide the review date for the plan when return to full-time education will be decided:

|  |  |
| --- | --- |
| Review date (dd/mm/yyyy) |  |

A review should take place within a maximum of four school weeks of the temporary part-time timetable starting.

Which multi-agency plan has been used to agree this part-time timetable with parents/carers:

|  |  |
| --- | --- |
| Personal Education Plan (PEP) |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Early Help Assessment (EHA) |  | Medical/Health Care Plan |  |
| Child in Need Plan |  | Team around the Family / Child (TAF / TAC) Plan |  |
| Child Protection Plan |  | Early Health Care Plan (EHCP / Annual Review Plan) |  |
| Looked after Child review Plan (LAC) |  | No Plan |  |
| Other (Please specify) |  |

**Other External professionals/agencies involved in the decision to have a part-time timetable:**

|  |  |  |  |
| --- | --- | --- | --- |
| Specialist Advisory Teacher |  | Virtual School |  |
| Access and Inclusion Officer |  | Social Worker |  |
| PRU |  | Youth Offending Service |  |
| Clinical Psychologist |  | HHTS Service |  |
| CAMHS / Mental Health Worker |  | Other Health Care Professional |  |
| SEND Officer |  | GP |  |
| Educational Psychologist |  | Paediatrician |  |
| Other (please specify) |  |

**Full-time provision should not be reduced until appropriate professionals have been involved**

|  |  |
| --- | --- |
| Name & role of person completing the form |  |

|  |  |
| --- | --- |
| Email |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone |  | Date form completed |  |

**Please enclose a copy of signed Parental Consent for a reduction in education provision with this form.**

**COMPLETED FORMS SHOULD BE RETURNED TO YOUR AREA INCLUSION TEAM VIA THE SCHOOL PORTAL:**

SEN WEST

SEND Barrow and South Lakes

SEN Carlisle and Eden

 **or by post to the following addresses:**

Inclusion Services               Inclusion Services               Inclusion Services

Cumbria County Council Cumbria County Council Cumbria County Council

Floor 4 West Cumbria House Cumbria House

Craven House Jubilee Road 117 Botchergate

Michaelson Road Workington Carlisle

Barrow in Furness CA14 4HB CA1 1RD

LA14 1FD

**End of Part Time Timetable - Date returned to full-time education**

|  |  |
| --- | --- |
| Date PTT Ended (dd/mm/yyyy) |  |

|  |  |
| --- | --- |
| Name & role of person confirming return to full time education |  |

|  |  |
| --- | --- |
| Date completed |  |

**Please re-submit form with completed End of Part Time Timetable detail to Inclusion Team detailed above.**