

**REQUEST FOR TEACHER ASSISTANT/NURSE
After School Activity / Field Trip**

ACTIVITY: _____

ADVISOR/CLASSROOM TEACHER: _____

ACTIVITY LOCATION: _____

DATE(s): _____ TIME: _____

STUDENT: _____ GRADE: _____

IEP Driven:	YES	NO
TA Type:	Shared 2:1 3:1	1:1

****For Field Trips ONLY:** TA Name and additional time required beyond the regular shift for the trip.
(ex: 12:00 - 1:30 or 10:00 - 12:00)

TA NAME: _____

EXTRA TIME REQUIRED: _____

DESCRIPTION OF ACTIVITY: _____

WHY DO YOU FEEL THE STUDENT REQUIRES A TEACHER ASSISTANT/NURSE TO PARTICIPATE:

HOW WILL THE TEACHER ASSISTANT/NURSE BE ASSISTING THE STUDENT IN THIS ACTIVITY:

PRINCIPAL'S SIGNATURE: _____ DATE: _____

DEPARTMENT OF SPECIAL SERVICES:	
DATE REC'D: _____	DATE OF POSTING: _____
DATE OF BOE APPROVAL: _____	
IEP MODIFICATIONS: _____ _____	
CST CM: _____	
NOTES: _____ _____	
IEP checked to verify TA or Nurse is IEP DRIVEN? _____	Initials: _____ Date: _____
Director of Special Services Verified/Approved: _____	Date: _____

