CAPISTRANO UNIFIED SCHOOL DISTRICT
Shorecliffs Middle School

INDEPENDENT STUDY REQUEST FORM

Student Name: _____ Grade: _____

Parent Name: _____ Phone Number _____

Parent Email: _____ (you will receive important info to email provided)

Dates of Absence _____ to _____ Date return to school _____

Total number of school days requested _____

Will the student have internet access? _____

Where will the student be traveling to? _____

Is the student receiving IEP services? _____

Please complete the ISC Request Form below and return to Mrs. Banks in the Attendance Office **no less than ten school days** prior to the first day of student's absence.

By filling out the request for an ISC, we acknowledge that we have read, understand and agree to comply with the criteria governing an Independent Study Contract.

_____ _____

Parent Signature/Date Student Signature/Date