

**Private Provider Plan**

- This plan must be completed annually by the private provider and returned to the Student Services Department at Central Office.
- When all paperwork is complete at Central Office, the form will be sent to the Principal and other appropriate staff.
- A substitute provider will not be provided by Dublin City Schools or the parents without prior consent of the district.
- Availability of staff will be determined by the district.
- The district has the option to phase out private provider services.

I. Student Information

Student's name: _____ Grade: ____ School: _____ School year: _____

II. Primary Services / Supports Being Provided by Private ProviderNursing services: ☐ Other: _____**III. Private Provider Information**

Name/title: _____

Contact information: Home _____ Cell _____ Other _____

Employer: _____

Name of liability insurance company: _____

Name of health insurance company: _____

Name of Prescriber writing orders: _____ Phone: _____

IV. Private Provider's School Schedule with Student

1. Please list the days and hours private provider will be with student at school or activities.
2. Will private provider be accompanying student to and from school? Yes ☐ No ☐
If yes, will private provider be riding the bus with student? Yes ☐ No ☐
If no, please list how student will get to and from school.
3. Please outline the daily schedule of care to be provided by the provider (use back of page if needed).
4. What plan is in place should private provider be absent for all or part of the school day/activities?

I have read and agree to follow the provisions of the District's *Private Provider Administrative Guidelines* (3120.091). I fully understand the nature of this position regarding confidentiality.

By typing your name below, you agree that your typed signature is the legal equivalent of your manual signature on this form. You may also print, hand-sign, and return this form if you prefer.

Parent signature: _____

Date: _____

Private Provider signature: _____

Date: _____

Student Services signature: _____

Date: _____

For CO use only

Check as completed:

☐ BCI&I/FBI ☐ Drivers License/ID

Check as forms received:

☐ 3120.09 F1 Private Provider Plan☐ 3120.09 F2 Liability Release for Parent/Guardian of Student Receiving Private Provider Services or Support☐ 3120.09 F3 Liability Release for Private Providers