

HARLAN COUNTY BOARD OF EDUCATION – HOME/HOSPITAL PROGRAM FORM

District: _____ **Student:** _____ **Date of Birth:** _____

Grade: _____ **IEP on File:** _____ Yes _____ No

School Name: _____ **Reason for Admission:**

Year Beginning: _____ **Medical** _____ **Mental Health** _____ **Complications from Pregnancy**

Year Ending: _____ **If admission is based on mental health reasons, was the student served in the:**

Teacher Name: _____ **Home** _____ **Hospital** _____ **Both**

Record of Instruction in Minutes – Please put a '60' in each box where a visit was made to reflect a 1 hour visit and leave each remaining box blank where visits have not been made. When the month ends, please total the minutes up in the far right column. Keep the original of this document until the HH placement ends and submit a copy every time you submit paperwork. This document should include only 1 student.

MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total Min.
AUGUST																																
SEPTEMBER																																
OCTOBER																																
NOVEMBER																																
DECEMBER																																
JANUARY																																
FEBRUARY																																
MARCH																																
APRIL																																
MAY																																
JUNE																																

- Instructions:**
- Fill in all blanks
 - Reason for Program Admission must be completed

Note: Kentucky school districts should maintain Home/Hospital Program forms within the school district. Forms will be requested for inspection during scheduled Attendance Reviews.

Teacher Signature: _____

If more than one teacher provides instruction, they must sign below:

Teacher Name (Print): _____ **Teacher Signature:** _____

Teacher Name (Print): _____ **Teacher Signature:** _____

Teacher Name (Print): _____ **Teacher Signature:** _____

Dates of Instruction: _____