HOME AND HOSPITAL TEACHING RECORD

Teacher's Name _____ School _____

Student's Name _____ Grade _____

Student's Address _____ Student's Phone _____

Parent or Guardian Name _____

Special Education Student:

☐ Yes ☐ No

Please check one of the following:

☐ Self-Contained Resource
☐ Cluster
☐ Special School
☐ 504 Student

Date of Visit	Arrival Time	Departure Time	Miles From School To Student's Home and Back to School	Comments

Parent or Guardian's Signature _____
(Monthly)

Principal's Signature _____ Date referred _____ Date terminated _____
(Monthly) (Not to exceed 15 school days without permission of Area Superintendent)

For payment of services, return copy of this form with the payroll time sheet and mileage report form to Instruction–Northeast Area–District Office.

Distribution of copies: District Office ● Home and Hospital Teacher ● Principal