

## 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 \_\_\_\_\_  
(Monthly)

Date referred \_\_\_\_\_ Date terminated \_\_\_\_\_  
(Not to exceed 15 school days without permission of Area Superintendent)

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