# [Home/Hospital Program Form
## _____ District  _____ School

Student: _____

Date of Birth:___/___/_____          Grade:_____

School Year: 20___ - 20___

Teacher name:_____

Home Hospital Beginning Date: _____

Projected HH End Date: _____

Extension Date (if applicable): _____

Reason for Admission:

Reason for Admission: _____

_____Medical _____Mental Health _____Complications from Pregnancy

Individualized Education Program (IEP) on file: _____Yes _____No

If IEP on file, date of ARC meeting where home/hospital placement was decided: _____

If admission is based on mental health reasons, was the student served in the:
_____Home _____Hospital _____Both

If no IEP on file, date of HH determination by committee: _____

If applicable, contract services provided by: _____
(Please attach contract and educational service plan from provider)

## Record of Instruction in Minutes

| 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 MINUTES |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| AUGUST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SEPTEMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| OCTOBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOVEMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DECEMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| JANUARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| FEBRUARY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MARCH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| APRIL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MAY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| JUNE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| JULY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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 (please print): _____
Teacher signature: _____

Teacher name (please print): _____
Teacher signature: _____

Dates of instruction: _____