STUDENT NAME: DOB:	PERSONAL HEALTH CARE SERVICES LOG	MONTH/YEAR:
CLASSROOM TEACHER:	BUILDING:	DISTRICT:

SERVICE CATEGORY	WEEK OF:					WEEK OF:					WEEK OF:					WEEK OF:					WEEK OF:				
	M	T	W	TH	F	M	T	W	TH	F	M	T	W	TH	F	M	T	W	TH	F	M	T	W	TH	F
AMBULATION																									
ASSIST W/SELF ADM. MEDS																									
BATHING																									
DRESSING																									
EATING/FEEDING																									
GROOMING																									
HANDS ON ASSISTANCE																									
MAINTAINING CONTINENCE																									
MEAL PREPARATION																									
MOBILITY POSITIONING																									
REDIRECTION FOR BEHAVIOR																									
RESPIRATORY ASSISTANCE																									
PERSONAL HYGIENE																									
SKIN CARE																									
TOILETING																									
TRANSFERRING																									
STUDENT ABSENT																									
HEALTH PROVIDER ABSENT																									

HEALTH CARE PROVIDER SIGNATURE: _____ **DATE:** _____
(Program Assistant(s) Signature)

DESIGNATED CASE MANAGER SIGNATURE: _____ **DATE:** _____
(Teacher's Signature)