CANYONS HOME AND HOSPITAL TEACHING RECORD

Teacher's Name ______________________________ School _________________________
Student's Name ______________________________ Grade _________________________
Parent /Guardian Name ________________________ Student's Phone ____ ____________
Student's Address ____

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)

For payment of services, return white copy of this form with the payroll time sheet and mileage report to Civil Rights and Accommodations **(short-term Home and Hospital ONLY).**

Distribution of Copies: Copy to: District Office Instruction; Copy to: Home and Hospital Teacher; Copy to: Principal

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