

PERSONAL HEALTH CARE SERVICES LOG

Student Name:	School District:	DOB:
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Classroom Teacher:	Month/Year:
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Health Care Providers:

Type of Service	Week of:					Week of:					Week of:					Week of:									
	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F
Eating/Feeding																									
Respiratory Assistance																									
Transferring																									
Personal Hygiene																									
Mobility/positioning																									
Muscle Strengthening																									
Medicaid Equipment Maintenance																									
Assistance w/self-administered medication																									
Redirection/intervention for Behavior																									
Health Related Function Through Hands on Assistance																									

Summary:

Signature/Date: