

**KENTUCKY DEPARTMENT OF EDUCATION
HOME/HOSPITAL PROGRAM**

DISTRICT NUMBER 061
Breathitt County
 YEAR BEGINNING August 07, 2025
 YEAR ENDING May 13, 2026
 TEACHER _____
 TEACHER SSN _____

STUDENT _____
 GRADE _____
 REASON FOR PROGRAM ADMISSION _____ MEDICAL _____ MENTAL HEALTH _____ PREGNANCY**
 IF ADMISSION IS BASED ON MENTAL HEALTH REASONS, WAS THE STUDENT SERVED IN THE:
 HOME _____ HOSPITAL _____ OR BOTH _____
 IEP ON FILE: _____ YES _____ NO

MONTH	RECORD OF INSTRUCTION IN MINUTES																															TOTAL MINUTES
	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	
JULY																																
AUGUST				PD	PD	OP																										
SEPTEMBER	H																															
OCTOBER	B	B	B																													
NOVEMBER																								B	B	B	H	B				
DECEMBER																							B	B	B	H	B			B	B	B
JANUARY	B	B																														
FEBRUARY																																
MARCH																														B	B	
APRIL	B	B	B																													
MAY																																
JUNE																																

INSTRUCTIONS:

Fill in all blanks.

Reason for Program Admission must be completed.

**Admission must be a result of complications from pregnancy.

If more than one teacher provides instruction, they must sign below.

TEACHER NAME (please print) _____

TEACHER SIGNATURE _____

DATES OF INSTRUCTION _____

TEACHER NAME (please print) _____

TEACHER SIGNATURE _____

DATES OF INSTRUCTION _____