

KENTUCKY DEPARTMENT OF EDUCATION
HOME/HOSPITAL PROGRAM

DISTRICT NUMBER 061 Breathitt County STUDENT _____
 YEAR BEGINNING August 07 2025 GRADE _____
 YEAR ENDING May 13 2026 REASON FOR PROGRAM ADMISSION _____ MEDICAL _____ MENTAL HEALTH _____ PREGNANCY** _____
 TEACHER _____ IF ADMISSION IS BASED ON MENTAL HEALTH REASONS, WAS THE STUDENT SERVED IN THE:
 TEACHER SSN _____ HOME _____ HOSPITAL _____ OR BOTH _____
 IEP ON FILE: YES _____ NO _____

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