SCHOOL HEALTH AIDE ENTRY FORM

STUDENT:

D.O.B:

SCHOOL / Teacher: Mid-Valley / /

SHA: _____

REPORT DATE: _____**TO**_____

SERVICE KEY
T = Transferring & Ambulating
F = Assistance w/ food, nutrition, & diet activities
B = Bowel & Bladder care
R = Redirection & Intervention for behavior

During the time worked, for each 15-minute increment below, write in the appropriate service code from the service key to the right. At the end of each day, total the number of 15-minute increments documented for each service in the total column area to the right.

Week 1 AM	DATE	7:00 AM	7:15	7:30	7:45	8:00	8:15	8:30	8:45	9:00	9:15	9:30	9:45	10:00	10:15	10:30	10:45	11:00	11:15	11:30	11:45	12:00
DAY 1																						
DAY 2																						
DAY 3																						
DAY 4																						
DAY 5																						

TOTAL # of 15-min increments	T	F	B	R
DAY1				
DAY2				
DAY3				
DAY4				
DAY5				

Week 1 PM	Date	12:15 PM	12:30	12:45	1:00	1:15	1:30	1:45	2:00	2:15	2:30	2:45	3:00	3:15	3:30	3:45	4:00	4:15	4:30	4:45	5:00	5:15
DAY 1																						
DAY 2																						
DAY 3																						
DAY 4																						
DAY 5																						

TOTAL # of 15-min increments	T	F	B	R
DAY1				
DAY2				
DAY3				
DAY4				
DAY5				

TEACHER SIGNATURE

_____

Week 2 AM	Date	7:00 AM	7:15	7:30	7:45	8:00	8:15	8:30	8:45	9:00	9:15	9:30	9:45	10:00	10:15	10:30	10:45	11:00	11:15	11:30	11:45	12:00
DAY 1																						
DAY 2																						
DAY 3																						
DAY 4																						
DAY 5																						

TOTAL # of 15-min increments	T	F	B	R
DAY1				
DAY2				
DAY3				
DAY4				
DAY5				

Week 2 PM	Date	12:15 PM	12:30	12:45	1:00	1:15	1:30	1:45	2:00	2:15	2:30	2:45	3:00	3:15	3:30	3:45	4:00	4:15	4:30	4:45	5:00	5:15
DAY 1																						
DAY 2																						
DAY 3																						
DAY 4																						
DAY 5																						

TOTAL # of 15-min increments	T	F	B	R
DAY1				
DAY2				
DAY3				
DAY4				
DAY5				

TEACHER SIGNATURE

_____

I certify that I have provided the services above and the information on this form is accurate to the best of my knowledge.

SHA SIGNATURE: _____

DATE: _____

To the best of my knowledge, I certify that the services on this form have been provided under my direction, per IDPA's definition in the U200, by the practitioner above.

SUPERVISOR NAME: _____

SPMP CATEGORY: _____

SUPERVISOR SIGNATURE: _____

DATE: _____

SUPERVISOR NAME: _____

SPMP CATEGORY: _____

SUPERVISOR SIGNATURE: _____

DATE: _____