BERENECE CARLSON HOME/HOSPITAL SCHOOL

HOME TEACHER WEEKLY SCHEDULE

FAX # (818) 505-0246

PLEASE FAX EVERY MONDAY MORNING

TEACHER NAME_____ #_____ HOME PHONE _____ VOICE MAIL EXT. # _____

(First 3 digits of .employee #)

SCHOOL MAIL SITE_____ MAIL REGION (If elementary) _____ PAGER/CELL_____

DATE: FROM_____**20**____ **TO**_____**20**____ CARLSON REP. _____ VOICE MAIL EXT. **# (7676)**____

STUDENT NAME	IEP	MAP PAGE & COORD.	STUDENT PHONE NUMBER	MEDICAL EXP. DATE	MONDAY *LUNES*	TUESDAY *MARTES*	WEDNESDAY *MIERCOLES*	THURSDAY *JUEVES*	FRIDAY *VIERNES*
					In Out	In Out	In Out	In Out	In Out
					In Out	In Out	In Out	In Out	In Out
					In Out	In Out	In Out	In Out	In Out
					In Out	In Out	In Out	In Out	In Out
					In Out	In Out	In Out	In Out	In Out
					In Out	In Out	In Out	In Out	In Out
					In Out	In Out	In Out	In Out	In Out

TEACHER'S SIGNATURE _____

INSTRUCTIONS:

1. Complete teacher information.
2. Indicate dates of week reported.
3. Print the name, if the student has an IEP, map page and coordinates, telephone number and medical expiration date of scheduled students.
4. Indicate the **beginning** & **ending** instructional time in each daily slot.
5. Sign the Weekly Schedule.
6. Mail or Fax the Weekly Schedule to the HIP office. **The schedule must be received by 8:00a.m., Monday.**
7. Notify your representative **immediately** of any changes in schedule.