SEAS

2026-27 DSC HEALTH AIDE SERVICE RECORD

IEP Begin DATE: / / **IEP End DATE: / /**

A) Student Name LAST: _____ **FIRST :** _____ **B) DOB:** _____ **C) GENDER:** _____

D) Health Aide Name: LAST _____ **FIRST:** _____ **E) School:** _____ **F) District:** _____

Activities of Daily Living :	**MAX MINUTES/day on IEP- for ALL activities below:**	

G) *Please Circle Month: ------->* **July Aug Sept Oct Nov Dec Jan Feb Mar April May June**

H) *Please Enter Dates : --->*

	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F
eating/feeding																									
dressing																									
toileting																									
transfers																									
positioning																									
mobility																									
grooming																									
use of assistive devices																									
safety monitoring																									
TOTAL daily minutes																									
Provider Initials																									

I certify that this information is accurate - all services are reflected on the IEP.

Signature (IN BLUE OR BLACK INK): _____ **DATE:** _____