

PRESTIGE HOME HEALTH CARE



HOME HEALTH/HOME CARE EMPLOYEE NAME/TITLE AIDE WEEKLY VISIT RECORD

	When completin					le Assi	anmen		PLOYEE NO
		SUN							WEEK OF
A	ГЕ								/ /
M	E IN:	□AM	□ AM	□AM	□ AM	□ AM □ PM	□AM	□ AM	THROUGH
	OUT:	□PM □AM	□PM □AM	□PM □AM	□PM □AM	□AM	□PM □AM	□PM □AM	/ /
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-		SUN	MON		VVLD	1110		SAI	COMMENTS (All confinents must be da
	T								
	P								
	R								
_	Weight / Pain Rating (0 - 10 scale)								
	Tub / Shower								
	Bed Bath - Partial/Complete								
┝	Assist Bath Chair								
	Personal Care Assist with Dressing						1		
	Hair Care								
	Shampoo						$\overline{\mathcal{O}}$		
	Skin Care						•		
	Foot Care								
	Check Pressure Areas								
	Nail Care				. (7)				
	Oral Care								
	Clean Dentures			10)		, (
	Other (specify):			7					
	Assist with Elimination			5					
	Catheter Care					*			
	Ostomy Care								
	Record Intake/Output	4	V		7				
	Inspect/Reinforce Dressing		* *						
_	Medication Reminder	1							
L	Other (specify):								
	Assist with Ambulation - WC/Walker/Cane								
	Assist with Mobility: Chair Bed/ Dangle/Commode/Shower/Tub								
L	ROM Active/Passive Arm R/L Leg R/L								
	Positioning-Encourage Assist hrs								
	Exercise Per PT/0T/SLP Care Plan								
L	Other (specify):								
	Meal Preparation								
	Assist with Feeding								
	Limit/Encourage Fluids Grocery Shopping								
	Other (specify):								
H	Wash Clothes								
	Light Housekeeping - Bedroom/Bath-								
	room/Kitchen - Change Bed Linen								
	Equipment Care								
_	Other (specify):								
	Last Bowel Movement								
РΊ	ID PERFORMED VIA NAME, I	DOB, AN	D ADDR	ESS	EMP	LOYEE	SIGNAT	TURE/D	ATE: / /
Сс	mmunication with Agency/Supervisor:				_ Signa	iture:			1 1
	NT/CLIENT NAME Last First Middle Init	tial					MR #		Date



HOME HEALTH/HOME CARE AIDE WEEKLY VISIT RECORD

EMPLOYEE NAME	
FMPLOYEE NO	

	When complet								ent Sheet		
	DAY	SUN	MON	TUE	WED	THU	FRI	SAT	WEEK OF		
DATE									/ /		
TIME	IN:								THROUGH		
TIME	OUT:								/ /		
	ACTIVITIES	SUN	MON	THE	WED	THU	FRI	SAT	COMMENTS (All comments must be dated)		
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4 —	P										
VITALS	R										
	Shower										
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m	Chair Bath										
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OMING 	Assist with Dressing						7				
>	Hair Care							•			
ō	Shampoo						\mathcal{O}^{\cdot}				
요 -	Skin Care)				
ΰ	Check Pressure Areas					Δ					
GII = N 					4	1					
덖	Oral Care					,					
<u>υ</u> —	Clean Dentures				XV						
<u> </u>	Other (specify):										
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	A - circle with Elization 4th -										
<i>σ</i> —	Assist with Elimination					Y					
₩—	Catheter Care Ostomy Care		1		XX						
≳—	Record Intake/Output		()	•	 						
<u> </u>	Inspect/Reinforce Dressing										
PROCEDURES	Medication Reminder:	7		- V							
<u>п</u>	Other (specify):	17	(
	Ambulation Assist - WC/Walker/Cane	7.									
_	Assist with Mobility: Chair										
	Bed/ W/C /Commode/Shower Chair										
É	Positioning - Encourage Assist hrs										
ပ္စ္ —	Other (specify):										
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NO I KI	Meal Preparation										
¥	Assist with Feeding										
ź	Grocery Shopping										
	Wash Clothes										
	Light Housekeeping - Bedroom/Bath- room/Kitchen - Change Bed Linen										
~	Equipment Care										
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<u> </u>											
-											
	PATIENT INITIAL										
SIGNA	TURES/DATES	<u> </u>		,				<u> </u>			
	oyee		/		Patient/	Client					
			Dat	ie .			Date				
PATIEN	IT/CLIENT NAME Last First Middle Init	tial					MR#				



Employee .

HOME HEALTH/HOME CARE AIDE WEEKLY VISIT RECORD

EMPLOYEE NAME ___ EMPLOYEE NO. ___ PATIENT/CLIENT NAME - Last, First, Middle Initial Patient/Client Signature When completing, be sure to follow the Aide Assignment Sheet codes. DAY-SUN MON TUE WED THU FRI SAT **WEEK OF** TIME IN TIME OUT AIDE's INITIALS THROUGH PATIENT'S/CLIENT'S INITIALS SUN MON TUE WED THU FRI SAT **ACTIVITIES** Bed - Tub/Shower Bed Bath Partial/Complete Assist Bath Chair ВΑ Personal Care Assist with Dressing Hair Care Brush/Shampoo/Other Skin Care/Foot Care (Hygiene) Check Pressure Areas Shave/Groom/Deodorant Nail Hygiene - Clean/File/Report Oral Care - Brush/Swab/Dentures Elimination Assist Diaper Change/Perineal Care Catheter Care Ostomy Record Output/Input Inspect/Reinforce Dressing Assist with Medications T - Oral/Auxiliary/Rectal Pulse - Site and Results Respiration - Results BP - Site and Results Weight - Results Ambulation Assist - WC/Walker/Cane Mobility Assist ROM - Active/Passive Positioning Encourage/Assist to Turn q _____Hrs Exercise - Per PT/OT/SLP Care Plan Diet Order: Meal Preparation Assist with Feeding Limit/Encourage Fluids Grocery Shopping Wash Clothes Light Housekeeping - Bedroom/Bathroom/Kitchen - Change Bed Linen **Equipment Care** Assist with Pain Management SIGNATURE/DATE



and have performed all services in accordance to Agency policy

I certify that I have received no injuries during this assignment.

HOME HEALTH AIDE NOTE

Patient's Nar					HHA Name:				
	Please Print					Please Print			
Patient's Nu	mber				HHA Numb	er			
			D) #05-0 /			_			
		DATE OF SE	RVICES /	FECHA DE	SERVICIO				
	MENTAL STA	TUS	SUN	MON	TUE	WED	THU	FRI	SAT
Alert / Alerta									
Confused / C									
Forgetful / C									
	e / No responde								
	BATHING / PERSON	AL CARE							
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	año en la bañero				ļ				
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	/ Cuidado de la Boca								
Shampoo/C Shave/Afeita	· · · · · · · · · · · · · · · · · · ·								
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	sistance / Asistir en Ves						-		
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	otion / Ejercicios de mo ith Assist / Asistencia p		16	<					
	·	ular con Bastón / Andador	1/2						
Ambulate wit	NUTRITION								
Meal Prenar	ation / Preparar comida		9	$()$ \vee					
	eeding / Asistir Cliente		•	X					
	ELIMINATIO								
Client to To	ilet / LLevar el Cliente								
	side Commode / Cliente								
Incontinent C	Care / Diapers / Cuidado	de Incontinencia / Pañales							
	ormal / Abnorma								
Last BM /	Ultima vez al baño	7/4							
	HOMEMAKING *	TASKS							
Laundry / La	ıvar								
Grocery Shop	pping Done / Ir al Merca	do							
Kitchen / Cod	cina								
Bathroom / B	año								
Client's Bedro	oom / Dormitorio								
	TPR								
Temperati	ure								
Pulse									
Respiratio	n								
and the second			عن يعن دددد						*************
DAY	DATE		C, C	MMEN	112				
SUNDAY									
MONDAY									
TUESDAY									
WEDNESDAY									
THURSDAY									
FRIDAY									
SATURDAY									
I hereby certify	v that the information co	ntained in this document is tr	rue						

HHA Signature:

(Firma de asistente)



HOME HEALTH AIDE FLOW SHEET

Patient:							CR	#:		Er	mp.#	
Month	20	Sun		Mon		Tues		Wed	Thurs		Fri	Sat
Temperature	Pulse											
r emperature	Respirations	1		•								
Bath: Bed	Commode											
Shower	Tub											
Oral Care	Back Rub											
Shampoo	Shave											
Feed Patent	Encourage Fluids											
Nail Care	Dress Patient											
Elastic Hose	Abdominal Binder											
								<u>-9</u>				
	t in Bag)				
Bed Making	Laundry					4						
Meal Preparation	Shopping					.0		C				
Turning	Positioning				Ċ							
Transfer	Hoyer Lift				7		X					
	lker Cane			19)							
ROM: Upper	Lower					X						
Exercise: PT	ST OT		V			7.						
Condition: App		N	* *	_ \								
Skin	7	7	- (1	•							
Pair	n (Location)											
Anxious Alert C	Confused Depressed Ostomy											
Incontinent: Urine	Feces											
Bedpan BS Com	mode Bathroom											
AIDE ASSIGNMENT RI												
EMPLOYEE INITIALS												
COMMENTS (Include d	ate, problem, name of sup	onvicor	notific	۹)،								
COMMENTS (ITICIdate d	ate, problem, name or sup	Jei visoi	Houne	u).								
C - Care Given												
Y –Yes X–N o Problem												
											Α	ide Signature

WHITE: CHART YELLOW: COPY



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Mobility A								+		+								
ROM-Acti		ve																
Positioning	-Encoura	ge/Assis	st	+				+										
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Meal Prepa								_		1								
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Wash Clot Light House		Redroom	n/Rath					\perp		-								
room/Kitcl							L											
Equipment	Care																	



Total Home Health Care, Inc. 🥒

HOME HEALTH AIDE NOTE

MR.#	
	□ Chargeable

PRIENTS LAST HAME PROSE WITH DAY YEAR ENDING: PAPER HAME PAPER	Pt Sign:			_ Date:_					□ Non	-Chargeable
Place with NTMUS in each year	PATIENT'S LAST NAME		FIRS	TNAME				WEEK	MONTH DA	YEAR
Chest-christ-stem an salor week DO FROT do anywhing that is DATE PERSONIAL CARE ACTIVITIES BATH Set Shower ShampoolHair Care Monin Care Orsane-& Report changes in skin Speak Shave Orsane-& Report										
Chest-christ-stem an salor week DO FROT do anywhing that is DATE PERSONIAL CARE ACTIVITIES BATH Set Shower ShampoolHair Care Monin Care Orsane-& Report changes in skin Speak Shave Orsane-& Report	Please, write INITIALS in each visit	IDE'S INI	TIAL						1	
Visit Do I NOT do enlything that is motet you do rely to the post of the post		(HENTS II	VIIIAL	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
BERTH Bet Shower Showe	visit DO NOT do anything that is	БАТ	= 1							, , , , , , , ,
BATH. Bed Shower Share Mouth Care Dress Shave Observe & Report changes in skin Special Skin Care Naul Care Fingers Toes Transfer Activity. Elrkoyr lift. Elled to Chair Walking cane, walker Up with Help Foot Care Assist with feeding Incontinence Care Empty Catheter Bag, amount Assist, commods, bedoan untail, tollet Empty solomy equipment Supervision of Self Administration of oral Medications. HOUSEMOD In HylloENE TASKS Prepare and serve meal and/or snack Laundy, P.R. Na Clean Client's Bathnoon Clean Richen Wash Dishes Do Groenies Make / Change Bed Wash Dishes Do Groenies Balker / Change Bed Wash Dishes Do Groenies Self-Administration Gran Richen Wash Dishes Do Groenies Self-Administration Clean Richen Wash Dishes Do Groenies Self-Administration Clean Richen Wash Dishes Do Groenies Make / Change Bed Wash Dishes Do Groenies Self-Administration Clean Richen Wash Dishes Do Groenies Wash Dishes Wash				1		ļ			<u> </u>	
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Shave Doberve & Report changes in skin Special Skin Care Nail Care Fingers Toes Transfer Activity:									+	
Observe & Report changes in skin Special Skin Care Nail Care									+	
Special Skin Care Special Skin Care Fingers Toes		1							+	
Nail Care		<u> </u>							+	
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WORKED DURING THE WEEK AND THAT THEY WERE PROPERLY VERIFIED AM Noon Noon Noon Noon Night	I CERTIFY THAT THE HOURS SHOWN									
EMPLOYEE NAME Noon Noon Night	REPRESENT MY TOTAL HOURS	1 000	1							
EMPLOYEE NAME PM Night *	THAT THEY WERE PROPERLY			<u>/</u> ,	<u>/</u> ,			<u>/</u> ,		
EMPLOYEE NAME PM Night *	VERIFIED									
PM Night *		Noon								
PM Night *	EMBLOWEE NAME									
Night *	EMPLOYEE NAME	I PM I								
EMPLOYEE SIGNATURE Night *				/					/	
EMPLOYEE SIGNATURE INIGHT		[4	//		//				
EMPLOTEE SIGNATURE	EMPLOYEE SIGNATURE	INIGHT	**							



HOME HEALTH/HOME CARE AIDE WEEKLY VISIT RECORD

EMPLOYEE NO. _____

	When comple	ting b	e sure	to fo	llow t	he Aid	de /	٩ss	ignm	ent Sheet
	DAY	SUN	MON	TUE	WED	THU	=	₹I	SAT	WEEK OF
DAT	E									/ /
TIME	IN:									THROUGH
TIME	OUT:									1 1
	ACTIVITIES	SLIN	MON	THE	WED				SAT	COMMENTS (All comments must be dated)
10	T	SUN						`	SAI	COMMENTO (All Comments must be dated)
VITALS	P							_		
MT.	R									
	Shower w/ Chair									
ВАТН	Bed Bath - Partial/Complete							\neg		
/19	Chair Bath									
	Personal Care									
	Assist with Dressing								,	
	Hair Care						1			
	Shampoo					_()			
	Skin Care									
	Foot Care				-					
	Check Pressure Areas									
	Nail Care									
/B	Oral Care				9		(
OMING	Clean Dentures									
ÉL	Other (specify):									
≥				7						
\circ	Assist with Elimination		C	2						
$\circ \square$	Change Diaper				X					
<u>ال</u> ا	Perineal care	•								
	Other (specify):		X		7					
Щ		N	• •							
길 	Medication Reminder:	11.								
	Other (specify):	7								
YG -	Ambulation Assist - WC/Walker/Cane Assist with Mobility: Chair									
Ĺ	Bed/ W/C /Commode/Shower Chair									
	ROM Passive Arm R/L Leg R/L									
	Exercise Per PT/0T Care Plan									
	Other (specify):									
NUTRITION	Meal Preparation									
<u> </u>	Assist with Feeding									
Ž	Grocery Shopping									
<u>~</u>	Wash Clothes Light Housekeeping - Bedroom/Bath-									
П	room/Kitchen - Change Bed Linen Make bed									
	Change sheets									
	Companion							-		
-	Escort									
	Respite		-							<u> </u>
	Homemaker									
SIGNA	TURES/DATES	<u> </u>	<u> </u>	,	<u> </u>	<u> </u>	I			1 1
	loyee		 Dat	<u> </u>	Patient/	Client				
PATIEN	IT/CLIENT NAME Last First Middle Ini	tial					M	IR#		
	A HEN POEIEN HAME East Hist Middle Hitta									



HOME HEALTH AIDE NOTE

MR# ___



☐ AM Visit ☐ PM Visit

PATIENT'S LAST NAME	FIRST NAME	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
VITAL SIGNS:]]
☐ Temp / Pulse / Respira	ations							
BATH: 🗆 Shower								
□ Bed								
BSC Shawar Chair								
☐ Shower Chair ORAL HYGIENE								
☐ Brush Teeth								
Clean Dentures								
☐ Mouth care								
HAIR CARE								
☐ Comb/Brush Hair ☐ Shampoo	r							
NAIL/FOOT CARE								
□ Nail Cleaning/Filing	g 🗆 Fingers							
	□ Toes				O'			
OTHER								
□ Shave				_ ^ ·				
☐ Assist with Dressin☐ Skin Care with Lotio				41.				
☐ Skin Care with Lotic	on							
ACTIVITY								
☐ Bed rest			.65					
☐ Turn/Reposition in			13					
☐ Assist with Transf	fer							
□ Hoyer Lift			7 () ~				
☐ Assist with Ambulation								
☐ Assistive Device☐ Passive ROM Exerci		· O ·	$-\Theta$					
ELIMINATION	ises							
☐ Assist with bedpan/ur	rinal		_ \					
☐ Assist to bathroom/E	BSC		"					
☐ Empty Catheter drain								
□ Empty colostomy	bag							
□ Last BM								
☐ Perineal Care - Diap	er change							
NUTRITION Assist with Feedi	inge							
☐ Assist with Feedi☐ Prepare/Serve Light r								
☐ Frepare/Serve Light 1	iii vai							
□ Restrict Fluids:								
OTHER SERVICES AS PER PT REC	DUEST							
☐ Change/Straighten b								
☐ Clean/Straighten bed								
☐ Light grocery sh							1	
☐ Other:								
☐ Other:							l	
		1		1	1	1		
Comments:	start of care (To be	done on vour	first visit)					
		T T T T T T T T T T T T T T T T T T T	3 (1/31)	<u> </u>		I	Г	1
REPRESENT MY TOTAL HOURS	MEIN 🕨							
WORKED DURING THE WEEK AND THAT THEY WERE PROPERLY TIN VERIFIED	AE OUT							
VERIFIED	ME OUT 🚩							



AIDE ACTIVITY NOTE

Patient Name: ₋	
M.R #	

	SUN	MON	TUES	WED	THUR	FRI	SAT
DATE							
REGULAR VISIT							
REFUSE VISIT							
TIME IN:							
TIME OUT							
Temperature							
Pulse							
Respiration							
Last Elimination Bowel							
Urine							
Office							
Bath					_		
Bed-Complete							
Bed-Partial					4		
Shower-Standing/Sitting				-			
Shampoo							
Comb Hair				()			
Hands		L					
Oral Hygiene				^			
Shave		L		•			
Skin Care							
Perineal Care							
Nail Care (Do not cut)							
Assist: Turning Patient				V			
Assist: Transfer Bed/Chair							
Bedridden							
Maintenance of Body Alignment) 			
Wheelchair							
Ambulate with Assistance				_			
Ambulate with Cane			- 1 1,				
Ambulate with Walker		— — . T					
Assistance with Dressing		- 					
Bedpan	<u> </u>	<u> </u>		<u> </u>		<u> </u>	
0						 ₁	
Straighten Patient's Area							
Linen Change							
Clean Bathroom							
Clean Kitchen							
Personal Laundry					L	[
Preparation of Meal			L		L		
Serving of Meal					<u> </u>	<u></u>	
Feed Patient	0				ω		
Appetite	ır.	L sin		- Ire	nre	<u>×</u>	¥
Wash Dishes	ati	at at	at	atı	at	at	at
Grocery Shopping	g	E P	lg l	gn g		g	ng
	Patient Signatur	Patient Signatur	Patient Signatur	Patient Signature	Patient Signatur	Patient Signatur	Patient Signatur
Foley Catheter Care							
Empty Drainage Bag	<u> </u>	te			file	≗	
Output				g	& G	o	
Reinforcement of Dressing	<u> </u>					——	
Assist with Colostomy Care							
Assist with Brace							
							
(Type)							
Ace Bandage							
DATE:		COMMENTS:					-

HHA SIGNATURE	EMPLOYEE NUMBER
WITH MY SIGNATURE, I DO CERTIFY THAT THE SERVICES MENTIONED HAVE	TOTAL HOURS



HOME HEALTH AIDE NOTE

Patient's Nar	me:				HHA Name:								
Please Print						Please Print							
Patient's Nu	Patient's Number					er							
		DATE OF SEF	PVICES /	EECHA DE	- SERVICI	2626							
	MENTAL STATUS						Ŧ1111	EDI	CAT				
Alert / Alerta	MENTAL STATUS		SUN	MON	TUE	WED	THU	FRI	SAT				
Oriented/Orie					 '		+	\longrightarrow					
				 '	 '								
Forgetful / O				 '	 '	+	+	\longrightarrow					
	e / No responde			 '	 '	1	 						
	BATHING / PERSONAL C	SARE		 '	 '		+	$\overline{}$					
	Baño en cama		$\overline{}$		 		+	\longrightarrow					
	sure areas / chequear areas d		<i>_</i>	 '	 '								
	Ducha / Sitting / Sentado /	/ Standing / De pie		 '	 '		4						
	/ Cuidado de la Boca			 '	 				<u> </u>				
	hampu / Hair care			 '	 	47							
Shave / Afeita			لـــــــــــا	<u> </u>	<u> </u>			لــــــــــــــــــــــــــــــــــــــ					
	age / Masage con Loción		لــــــــا					لــــــــــــــــــــــــــــــــــــــ	<u> </u>				
-	/ Cuidado de las Uña		<u></u> /					لــــــــــــــــــــــــــــــــــــــ	<u> </u>				
Dressing Ass	sistance / Asistir en Vestir CI	liente	<u></u> /	<u> </u>					<u> </u>				
	TRANSFER / AMBULAT	rion	(<u> </u>		*								
Transfers Ass	sist / Asistir en Transferir Cliente	a											
Up in Chair / 5	Sentar en silla / Hoyer Lift / Gru	и а	()		,								
	ed Patient / Reposicionar Paciente		·	XU	1								
Range of Mo	otion / Ejercicios de movimle	ento			1, 2								
— —	Assist / Asistencia para ambular/Su		1	O_'	V/_'				ī				
	ith Cane / Walker / Ambular c		-7	<u> </u>	\								
-	NUTRITION	J	5		,								
Meal Prepar	ration / Preparar comida	J			-		 		ſ				
	eeding / Asistir Cliente a Cor	omer		1	<u> </u>				<i></i>				
	ELIMINATION	The state of the s	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	4			 	$\overline{}$					
Client to To	pilet / LLevar el Cliente al In	nodoro				$\overline{}$	 	$\overline{}$					
	dside Commode / Cliente al Ind			<u> </u>			 						
	Care / Diapers / Cuidado de Ir						 						
	care / Diapers / Cuidado de ir Iormal / Abnormal	.1CONUMENTAL A T AMAGES	///				 						
					+		+	\longrightarrow					
Last Bivi /	Ultima vez al baño						+						
·	HOMEMAKING TASK	KS		 '									
	var ropa personal y de cama				 '								
	opping Done / Ir al Mercado			 '	 '		+						
	cina / Bathroom /Baño/Bedroo			 ′	 	 '							
Make - Chan	ige bed / Hacer - cambiar ropa	a cama		 '	 								
L			لــــــــــا	 '	 	1	$oldsymbol{oldsymbol{oldsymbol{eta}}}$	لــــــــــــــــــــــــــــــــــــــ	<u> </u>				
<u></u>	TPR		لــــــــــــا	<u> </u>	<u> </u>	<u> </u>		لــــــــــــــــــــــــــــــــــــــ	<u> </u>				
Temperatu	ure		لــــــــــــــــــــــــــــــــــــــ	<u> </u>				لــــــــــــــــــــــــــــــــــــــ	<u> </u>				
Pulse			·	ſ <u></u> ′	<u></u>			Γ <u></u>	ί <u> </u>				
Respiratio	n		·						·				
DAY	DATE I				OMMENTS								
SUNDAY													
MONDAY													
TUESDAY													
WEDNESDAY													
THURSDAY													
FRIDAY													
SATURDAY													

I hereby certify that the information contained in this document is true, and have performed all services in accordance to Agency policy I certify that I have received no injuries during this assignment.

HHA Signature:	
Firma de asistente)	



C - Care Given **√** - Yes

X - No Problem

IN HOME SUPPORT SERVICES

PATIENT		<u> </u>					CR#:							
Month	20	Mon	Tues	Wed		Thu		Fri		Sat		Sun		
Bath: Bed	Commode													
Shower	Tub													
Oral Care	Back Rub													
Shampoo	Shave													
Feed Patent	Encourage Fluids													
Nail Care	Dress Patient													
Medical	Dental App.						$\overline{}$							
Beauty Salon														
Park						Q.								
Bed Making	Laundry)								
Meal Preparation	Shopping			7										
Shopping Mall			(2)		~								
Grocery Shopping	Errands),		7								
Ambulating Walker Cane					X									
Medications Pick Up			5))	/									
Mail Pick Up Empty Trash			1	K_										
Cleaning Bedroom		· O.	N											
Clean Bathroom		11.	\range											
Wash Dishes		" C) ,											
Vacuum / Sweep / Dust														
Meeting	- 1													
Reading	Math													
Follow Universal Precaution														
A.M.														
	P.M.			<u> </u>										
MON:		WED: _					FR	l:						
TUES:		THU: SAT						Γ:						
SUN					N:									
COMMENTS (Include date, problem, name of supervisor notified):														

Aide Signature _____