



Please describe how the lack of cognitive skill or vulnerability is affecting the child's behavior and what assistance must be provided to redirect or intervene during a behavioral episode: _____ _____ _____	Start __: __	Start __: __	Start __: __	Start __: __	Start __: __	Start __: __	Start __: __	Start __: __	Start __: __	Start __: __
	End __: __	End __: __	End __: __	End __: __	End __: __	End __: __	End __: __	End __: __	End __: __	End __: __
	# group __	# group __	# group __	# group __	# group __	# group __	# group __	# group __	# group __	# group __
	Mins _____	Mins _____	Mins _____	Mins _____	Mins _____	Mins _____	Mins _____	Mins _____	Mins _____	Mins _____
	PCA _____	PCA _____	PCA _____	PCA _____	PCA _____	PCA _____	PCA _____	PCA _____	PCA _____	PCA _____
	Start __: __	Start __: __	Start __: __	Start __: __	Start __: __	Start __: __	Start __: __	Start __: __	Start __: __	Start __: __
	End __: __	End __: __	End __: __	End __: __	End __: __	End __: __	End __: __	End __: __	End __: __	End __: __
	# group __	# group __	# group __	# group __	# group __	# group __	# group __	# group __	# group __	# group __
	Mins _____	Mins _____	Mins _____	Mins _____	Mins _____	Mins _____	Mins _____	Mins _____	Mins _____	Mins _____
	PCA _____	PCA _____	PCA _____	PCA _____	PCA _____	PCA _____	PCA _____	PCA _____	PCA _____	PCA _____
	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____

<b>(A) DAILY MINUTE TOTALS</b>										

**(B) Total minutes of the 10 days:** \_\_\_\_\_ ÷ 10 = **Average mins per day for daily log**  
 (Case Manager: use this number for IEP Services Page of PCA Support)

**(C)** \_\_\_\_\_

For situations that may require a personal care assistant to assist with ADLs and monitor a child for health related concerns **for the full day** at school, please add any pertinent details about this child. Such situations may be for a child who is medically fragile and needs assistance with multiple ADLs, needs constant intervention or redirection of behaviors, or both. *Documentation must clearly identify the child's specific medical needs, why constant continuous care is needed throughout the school day, and how the services provided relate to the child's medical needs.*

*This space can be used for additional comments or figuring totals, etc*

<b>Eating</b>	<b>Day 1</b>	<b>Day 2</b>	<b>Day 3</b>	<b>Day 4</b>	<b>Day 5</b>	<b>Day 6</b>	<b>Day 7</b>	<b>Day 8</b>	<b>Day 9</b>	<b>Day 10</b>
<input type="checkbox"/> Cueing and supervision of eating <input type="checkbox"/> Assistance with handwashing before/after eating <input type="checkbox"/> Transfers and positioning for eating <input type="checkbox"/> Serving and preparing food (opening, cutting, etc) <input type="checkbox"/> Feeding <input type="checkbox"/> Monitoring intake for medical reasons <input type="checkbox"/> Other: (please describe)  	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____
<b>Dressing</b>	<b>Day 1</b>	<b>Day 2</b>	<b>Day 3</b>	<b>Day 4</b>	<b>Day 5</b>	<b>Day 6</b>	<b>Day 7</b>	<b>Day 8</b>	<b>Day 9</b>	<b>Day 10</b>
<input type="checkbox"/> Assistance with choosing, putting on/off and changing clothing and boots/shoes <input type="checkbox"/> Manage braces or other orthotics <input type="checkbox"/> Laundering clothing that is soiled <input type="checkbox"/> Other: (please describe)  	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____
<b>Grooming</b>	<b>Day 1</b>	<b>Day 2</b>	<b>Day 3</b>	<b>Day 4</b>	<b>Day 5</b>	<b>Day 6</b>	<b>Day 7</b>	<b>Day 8</b>	<b>Day 9</b>	<b>Day 10</b>
<input type="checkbox"/> Assistance with basic hair care <input type="checkbox"/> Assistance with brushing teeth <input type="checkbox"/> Assistance with applying cosmetics and deodorant <input type="checkbox"/> Ensuring clothes are clean and properly fastened <input type="checkbox"/> Care of eyeglasses and hearing aids (batteries, positioning aids) <input type="checkbox"/> Assistance with blowing/wiping nose <input type="checkbox"/> Other: (please describe)  	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____
<b>Transfers</b>	<b>Day 1</b>	<b>Day 2</b>	<b>Day 3</b>	<b>Day 4</b>	<b>Day 5</b>	<b>Day 6</b>	<b>Day 7</b>	<b>Day 8</b>	<b>Day 9</b>	<b>Day 10</b>
<input type="checkbox"/> Assist with transferring child from one seating or reclining area to another, including Hoyer lift <input type="checkbox"/> Other: (please describe)  	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____	Start: End: PCA:  Start: End: PCA:  Start: End: PCA:  TM: ____

<b>Mobility</b>	<b>Day 1</b>	<b>Day 2</b>	<b>Day 3</b>	<b>Day 4</b>	<b>Day 5</b>	<b>Day 6</b>	<b>Day 7</b>	<b>Day 8</b>	<b>Day 9</b>	<b>Day 10</b>
<input type="checkbox"/> Assistance with ambulation, including use of a wheelchair. <input type="checkbox"/> Monitoring walking safely due to medical condition <input type="checkbox"/> Other: (please describe) _____	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:
	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:
	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____
<b>Positioning</b>	<b>Day 1</b>	<b>Day 2</b>	<b>Day 3</b>	<b>Day 4</b>	<b>Day 5</b>	<b>Day 6</b>	<b>Day 7</b>	<b>Day 8</b>	<b>Day 9</b>	<b>Day 10</b>
<input type="checkbox"/> Assistance with positioning or turning child for necessary care and comfort. <input type="checkbox"/> Other: (please describe) _____	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:
	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:
	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____
<b>Other Health Related Tasks</b>	<b>Day 1</b>	<b>Day 2</b>	<b>Day 3</b>	<b>Day 4</b>	<b>Day 5</b>	<b>Day 6</b>	<b>Day 7</b>	<b>Day 8</b>	<b>Day 9</b>	<b>Day 10</b>
<input type="checkbox"/> Assistance with range of motion and passive exercise to maintain a child's strength and muscle function <input type="checkbox"/> Assist with self-administered medication, including reminders to take medication, bringing medication to the child, open containers. <input type="checkbox"/> Interventions for seizure disorders that occur more than two times per week and require physical assistance to maintain safety <input type="checkbox"/> Procedures for complex health-related needs such as tracheostomy suctioning, ventilator support and other direct cares. (covered PCA services trained and supervised by a registered nurse) <input type="checkbox"/> Other: (please describe) _____	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:
	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:
	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:
	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____
<b>Personal Hygiene &amp; Toileting</b>	<b>Day 1</b>	<b>Day 2</b>	<b>Day 3</b>	<b>Day 4</b>	<b>Day 5</b>	<b>Day 6</b>	<b>Day 7</b>	<b>Day 8</b>	<b>Day 9</b>	<b>Day 10</b>
<input type="checkbox"/> Cueing and supervision of toileting <input type="checkbox"/> Transfer to and from toilet <input type="checkbox"/> Assistance with feminine hygiene <input type="checkbox"/> Cleansing the perineal area <input type="checkbox"/> Assistance with clothing <input type="checkbox"/> Assistance with washing/drying hands <input type="checkbox"/> Cleaning/sanitizing bathroom or diapering area <input type="checkbox"/> Skin care and skin inspections <input type="checkbox"/> Diapering <input type="checkbox"/> Other: (please describe) _____	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:
	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:
	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:	Start: End: PCA:
	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____	TM: _____

**TM = Total Minutes**

- 1) At the end of each day, please count up your total minutes for each area. Enter the numbers on the TM lines. If the student or para was absent for a day and there are no numbers to report, then skip the day and continue on when the student/para returns.
- 2) Add the minutes (TM lines) all together for a day and enter in the (A) Daily Minute Totals box on Page 1.
- 3) After 10 days, add up the Daily Minute Totals for the 10 days and enter on line (B)
- 4) Divide the (B) amount by 10 and enter in Box (C)

Student Name: \_\_\_\_\_