DONA ANA COUNTY EARLY HEAD START

Sign-In Record for Related Services Staff **Center** _____

DATE	CHILD'S NAME	TIME IN	TIME OUT	NAME OF PROVIDER STAFF (RELATED SERVICES)	PURPOSE FOR VISIT

Turn this form in to the Disabilities Specialist on the **last school day** of each month.

Sign In/DIS/6.01 10/01 6.08
Revised to EHS 6.15