Attachment C

DEPARTMENT OF MENTAL HEALTH SERVICES

Weekly Contact Log

2018-2019

Mental Health Services

Name of Mental Health Provider **Week of:**

Name of School Site:

STUDENT NAME	SERVICE	DATE	TIME FROM	TIME TO	NUMBER OF PARTICIPANTS	TOTAL HOURS	TOTAL MINUTES	COMMENTS
					TOTAL HOURS			

SS - Student Screening
PC - Parent Consultation
TC - Teacher Consultation
CC - Clinician Consultation
CM - Case Management
SA - Student Assessment
RK - Record Keeping

I certify that these services have been rendered to the students listed above

Signature: Administrature or Disignee

Date