



MENTAL HEALTH SESSION NOTES

STUDENT NAME: _____ DATE OF BIRTH: _____ SAU #: _____
DISTRICT OF LIABILITY: _____

Session Date: _____
 Start Time: _____
 Stop Time: _____
 Total Minutes: _____
 Circle One: (G) Group (I) Individual
 _____ Provider Initial: _____
 Consultation
 Family Counseling (student present at some point)
 Individual Treatment/Therapy/Services
 Group Treatment/Therapy/Services
 _____ Group Size (all students actually receiving the service)

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Unless so noted, school was in session and students were in attendance on all days recorded above. I have edited this form to correctly reflect services delivered on the above dates.

PRACTITIONER SIGNATURE: _____ DATE: _____
 PRACTITIONER PRINTED NAME: _____
 LICENSE / CERTIFICATION / DOE ENDORSEMENT: _____