# Mental Health Activity Record

**ACT.**_____

_____ _____

**DELEGATE AGENCY** **MENTAL HEALTH PROVIDER/AGENCY**

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**PROGRAM/SITE NAME** **CONSULTANT NAME**

| TYPE OF ACTIVITY/SERVICE (SPECIFY) | DATE PLANNED | DATE COMPLETED | COMMENTS |
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**[List of Activities/Services: Planning, Parent Orientation, Parent Education, Parent Consultation, Staff Development, Individual Observation, General Observation, Teacher Consultation, Crisis Counseling, Child Abuse/Neglect Prevention]**

THIS FORM IS TO BE COMPLETED DURING THE INITIAL PLANNING MEETING, THE DATE PLANNED COLUMN IS TO BE COMPLETED FOR THE ENTIRE PROGRAM YEAR, THE DATE COMPLETED COLUMN IS TO BE COMPLETED AS ACTIVITIES OCCUR, EITHER BY SITE DIRECTOR/NETWORK COORDINATOR OR SOCIAL WORKER.

**[DISTRIBUTION: Original-Program File Copy – Provider's]**