SCHOOL MENTAL HEALTH TREATMENT PLAN

TREATMENT PLAN		
Student's Name: _____ **School Name:** _____		
Is the student currently receiving mental health or related services? ☐ Yes ☐ No		
If yes, name of facility: _____ Address: _____ Phone number: __(_____)_____		
PRESENTING ISSUE(S): (Reason for mental health services)		
STUDENT HISTORY:		
MEDICATION(S):	Is the school nurse aware of medications? **(Provide copy)**	☐ YES ☐ NO
TREATMENT OBJECTIVE(S):		
TREATMENT GOAL(S):		
FREQUENCY OF SERVICES:	☐ Once a week ☐ Twice per month	☐ Once per month
TYPE OF SERVICES:	☐ Individual ☐ Group	☐ Family Session
INTERVENTION:		
CLINICAL DIAGNOSIS:		
Referral for Other Services (If needed)		

Student Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____

Mental Health Counselor Signature: _____ **Date:** _____