MANHASSET PUBLIC SCHOOLS
200 Memorial Place
Manhasset, New York 11030
SCHOOL AGE TREATMENT LOG

Student's Name _____ **Therapist Name:**_____

Location of Service: _____ **Service Provided:**_____

Service Frequency and Duration as indicated in IEP: _____

NOTE: **All sessions must be signed off by someone witnessing presence of services provider.

CODES: P - Service, MU – Make up session, C – Parent conference, CA – Child absent, TA – Teacher Absent, TM – Team Meeting, S – CSE meeting

Date of Session Start / End time Required	****Signature of Witness**	**Code**	**Notes on Session**
Date: _____ Start: _____ End: _____			Provider initials: _____
Date: _____ Start: _____ End: _____			Provider initials: _____
Date: _____ Start: _____ End: _____			Provider initials: _____
Date: _____ Start: _____ End: _____			Provider initials: _____
Date: _____ Start: _____ End: _____			Provider initials: _____

** **I certify all information listed above is correct (provider sig.)** _____ **Date:** _____

** **Supervisor's Signature** _____ **Date:** _____

** **Invoices will not be processed without required signatures, dates/times**