Clear Form

EXCEPTIONAL STUDENT EDUCATION
M-DCPS E/BD CLINICAL/ART THERAPY SCHEDULE

Name: _____ School Year: _____ Date: _____

MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY	
School:		**School:**		**School:**		**School:**		**School:**	
Phone:		**Phone:**		**Phone:**		**Phone:**		**Phone:**	
TIME	**ACTIVITY**	**TIME**	**ACTIVITY**	**TIME**	**ACTIVITY**	**TIME**	**ACTIVITY**	**TIME**	**ACTIVITY**
Total Students Serviced:		Total Students Serviced:		Total Students Serviced:		Total Students Serviced:		Total Students Serviced:	
Activity:		Art Therapy (include initials)		Counseling (include initials)		Case Management			
		AT-I: Individual AT-D: Dyad AT-G: Group (#) AT-A: Art Therapy Assessment		C-I: Individual C-D: Dyad C-G: Group (#) C-C: Class (#)		CM-D: Documentation CM-MS: Make-up Session CM-C/C: Contact/Conference CM-O: Classroom Observation		CM-C: Consultation CM-CS: Crisis Support CM-TM: Team Meeting	

***Submit to your Chairperson twice a year to accompany the Case Roster.**

Check (□) One: □ September □ January