Mental Health Activity Record

ACT._____

DELEGATE AGENCY _____

MENTAL HEALTH PROVIDER/AGENCY _____

PROGRAM/SITE NAME _____

CONSULTANT NAME _____

TYPE OF ACTIVITY/SERVICE (SPECIFY)	DATE PLANNED	DATE COMPLETED	COMMENTS

[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]