PLAN OF CARE

Date _____

Student Information

First Name_____Last Name _____

ID #_____ School _____

Type of Service (Check One)

☐ Speech/Language Therapy ☐ Physical Therapy ☐ Occupational Therapy

☐ Nursing ☐ Behavioral Services

Reason for Provision of Services

Goals/Objectives

Frequency and Duration (i.e. once per week for one year) _____

Amount (i.e. 30 minutes): _____

_____ _____ _____

Signature of Therapist **Title** **Date**

_____ _____

Print First Name **Last Name**