HERKIMER COUNTY PRESCHOOL RELATED THERAPY SERVICES
MONTHLY ATTENDANCE LOG & SIGNATURE VERIFICATION SHEET

Child's Name:_____ DOB:_____ M / F Month / Year of service:_____

School District:_____ School Year:_____

Service	Speech Therapy	Physical Therapy	Occupational Therapy	Other (such as TVI/O & M)
IEP Frequency:	Individual:	Individual:	Individual:	Individual:
	Group:			

Date:	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total
☑ Code:																																

☑ **Attendance Codes:** (Use attendance codes below for each session provided in the appropriate date of month)

P = Child Present • **X** = Individual Service Provided • **G** = Group Service Provided (include # in group, i.e. G3) •

CA = Child Absent • **TA** = Therapist Absent • **SC** = School Closed • * = UDO "face-to-face" with student

Date	Start time of visit	End time of visit	Service provider signature	Parent / adult responsible signature

ATTACHMENT I

sm PS Attendance Log (Word) updated 09/26/13