Return completed form to Pupil Services, attention Lindsey Strubin, via FAX at 301-334-7642 or lindsey.gregory@garrettcountyschools.org
GARRETT COUNTY PUBLIC SCHOOLS
TREATMENT PLAN
FOR EMOTIONAL/BEHAVIORAL REFERRALS

Name of Student: ________________________________ Date of Birth: ____________________

To be completed by treating medical professional. Please respond to each question.

1. Diagnosis: ________________________________________________________________

2. Is the student seen on regularly scheduled visits to your office? □ Yes □ No
   Frequency of Visits: __________________________ Date of Last Visit: ________________

3. Is the student currently in therapy? □ Yes □ No
   Therapist’s Name: ___________________________ Phone: __________________________
   Frequency of Visits: ________________________ Date of Last Visit: ________________

4. Is the student on Medication? □ Yes □ No
   Medication(s): ____________________________ Dosage: __________________________
   How will the medication(s) affect school performance? __________________________

5. Describe your treatment plan and how it addresses the student’s emotional condition. Please feel free to attach additional information as needed.
   __________________________________________________________________________

6. Is Home & Hospital Teaching the preferred academic placement? If so, why?
   __________________________________________________________________________

7. Are there any modifications or accommodations that could be made by the home school that would allow the student to return to/remain in the home school?
   __________________________________________________________________________

8. What is the plan to transition the student back to school?
   __________________________________________________________________________

9. What is the anticipated date of return to school? ________________________________

Treating Medical Professional’s Name: _______________________________________
   (Please print)

Address: ________________________________________________________________
Phone: __________________________________ Fax: __________________________
Signature: ___________________________ Date: ____________________________

□ Psychiatrist □ Licensed Clinical Psychologist □ Certified School Psychologist

Reviewed and recommended by GCBOE School Psychologist: ________________
Signature: ________________