SS-57-E(1)

BEAUFORT COUNTY SCHOOLS
Substance Abuse Counseling Sign Off Sheet

Name of Student: _____ Date: _____
School: _____

Date of Completed Assessment: _____

Counseling/Treatment Log:

Date of Counseling/Treatment Session	Counselor's Initials

Please check all that apply:

_____ Individual Counseling
_____ Family Counseling
_____ Problem Solving Skills
_____ Contingency Management for Parents
_____ Continued Therapy not Recommended at this Time
_____ Psychoeducation
_____ Coping Skills
_____ Behavior Modification

_____
Signature

_____
Name of Licensed Substance Abuse Professional

Date: _____

Contact Telephone Number: _____