**Student Name:**       **Medicaid #: Date of Birth: LEA/School:**

**Date of POC/HCP: Primary Care Provider: Phone #:**

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| **Date of Service** | **Goals(s) addressed** | **Service Description** | **Duration (in minutes)** | **Results/Response** | **Initials** |
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| **Initials/Full Name & Title Signature Date** (Keep current form with Treatment or Procedure Medical Order, attached. File in student’s folder when complete.) |