Early Head Start/Head Start Teachers

End of the Month Report – Mental Health/Disabilities

Center:_____ Month/Year_____

Complete All Blanks. If not applicable, place N/A in space provided. Turn in to Mental Health/Disability Coordinator at scheduled time. File in EOM Folder.

Disability Services

*Number of children receiving special services	
*Number of referrals for the month	
How many referrals of students to date	
Number of students with an active IEP	

***Please make sure to attach copies of special service reports and referrals of students.**

Social/Emotional Development

Number of Feeling Buddies Lessons	
Number of eDECA Assessments completed (October, February, May)	
Number of Mental Health Referrals for the month	
Number of Mental Health Referral to date	
Number of consultations provided by a Mental Health Professional	
Number of students who received classroom observations	
Number of children receiving Mental Health Services	

Staff Signature_____ Date_____