**Parent Child Development Corporation**
**Bridges Head Start**

## Special Services Report

*Instructions for completion: For each child receiving special services fill in the necessary information. Whenever the child is seen by the therapist, please have her fill in the date, time, activity, and sign. At the end of the month, the Head Start teacher should sign the form (verifying the report is accurate.) Turn in with EOM report.*

Child's Name: _____ Center: _____

Therapist: _____ Month: _____

| Date | Total Time | Activity | Therapist Signature |
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Head Start Teacher Signature: _____

Date: _____