



{ ALEINU } FAMILY RESOURCE CENTER

Mandated Assistance Program Student Treatment Recommendation

Name _____ Age _____ DOB ____/____/____
 Date ____/____/____ School _____ Grade _____

Treatment Recommendation:

- Individual Counseling: _____ x per week for _____ weeks
- Family Counseling: _____ x per month for _____ months
- Group Counseling: _____ x per week for _____ weeks
- 12-step groups: _____ x per week for _____ weeks

Other Recommendations:

I have been informed of the above treatment recommendations and understand that compliance is mandated by my child's school. I agree to act in accordance with these recommendations.

 Client Date Counselor Date

 Parent/Guardian Date Parent/Guardian Date