



Mary McDowell Friends School  
20 Bergen Street • Brooklyn, • New York 11201 • (718) 625-3939

Support Services Form  
2011-2012

MARY McDOWELL  
FRIENDS SCHOOL

In order to update our records, we would appreciate your filling out this form based on the outside support services your child received during the summer of 2011 or is planned for the school year of 2011-12. Please fill out this form—even if your child gets no additional supports or if you did so once before—and return it to us as soon as possible.

Thank you for your time and attention.

Deborah Edel  
School Psychologist

Name of Child: \_\_\_\_\_ Date: \_\_\_\_\_

No Additional Services

Speech/Language

On going  Summer only  Other \_\_\_\_\_

Provider: Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

How many sessions per week? \_\_\_\_\_

Occupational Therapy

On going  Summer only  Other \_\_\_\_\_

Provider: Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

How many sessions per week? \_\_\_\_\_

Psychotherapy/Counseling

On going  Other: \_\_\_\_\_

Provider: Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

How many sessions per week? \_\_\_\_\_

**Support Services Form**

**Tutoring:**

On going     Summer only     Other \_\_\_\_\_

Provider:            Name: \_\_\_\_\_

   Address: \_\_\_\_\_

   \_\_\_\_\_

   Phone: \_\_\_\_\_

How many sessions per week? \_\_\_\_\_

**Medicating Psychiatrist/Neurologist:**

On going     Evaluation only

Provider:            Name: \_\_\_\_\_

   Address: \_\_\_\_\_

   \_\_\_\_\_

   Phone: \_\_\_\_\_

How often? \_\_\_\_\_

**Other:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



I give the Mary McDowell Friends School permission to contact all service providers listed on this form and exchange information that will be beneficial to the school and the therapist(s) in order to help my child.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_