TRANSYLVANIA COUNTY SCHOOLS SUBSTANCE ABUSE OFFENDERS PROGRAM CONTRACT

Student
Addiction Assessment Verification Date
Facility Code Number*
Addiction Assessment Recommendations:

*The number assigned by the Division of Mental Health, Mental Retardation, and Substance Abuse Services of the North Carolina Department of Human Resources

INTERVENTION PLAN

STUDENT _____

School	Frequency/Duration	Completion	School
		Date	Supervisor
Education Program			
Teacher Advocate			
Counseling Service			
Financial Assistance			
Other			
Community Agency			
Court System	×		
Law Enforcement			
Social Services			
Support Group	$ \land \land$	-	
Other			
Participant			
School Service			
Program Completion			
Additional School			
Service			
Other			
I,	, verify that		
	-		
completed this plan on		·	

Signature

Family	Frequency/Duration
Financial Support	
Counseling Sessions	
Other	

I, ______, do hereby agree to enter into the Substance Abuse Offenders Program and to fulfill all the requirements of my individual plan including ______ hours of school service. I understand that failure to complete all requirements of this program, or to become involved in a second offense, will result in suspension for the remainder of the school year.

I, ______, understand that my child or I will pay the cost of the assessment and counseling services outside the school.

Parent/Guardian Signature

Student Signature

Date

Date

Completion Date

This student will be monitored by

APPROVED BY BOARD AND EFFECTIVE 8/22/88 REVISED 10/1/88 REVISED 7/25/94 REVISED 6/17/96 **Distribution:** Superintendent Principal Assessor Student