

**The School District of Escambia County STRESS REDUCTION AND
SCHOOL REENTRY PLAN**

(To be completed upon student's return to school)

Student:	Date of Birth:
Student Number:	School/Grade:
Parent/Guardian:	Date of Reentry to School:

Has your child received mental health assistance since being out of school? If so, please check and complete all that apply.

- My child was hospitalized for ___ days.
- My child saw a mental health counselor.
 - o *Name: _____ o Phone number: _____
- There was a change in my child's medication.
 - o *Physician/Psychiatrist: _____
 - o Phone number: _____
 - o What side effects should we watch for? _____
- Are there psychiatric symptoms we need to watch for? If yes, please list.** _____

How will your child be transported to and from school?

- My child will ride the bus to and from school.
- I will transport my child to and from school.
- Other: _____

How can the school contact you in the case of an emergency or if we have a question?

- Call me at: _____
- Call my designated contact (name): _____ at: _____

Do you feel you need additional information on mental health resources in your community?

- Yes. Please call me.
- No. I feel my current resources meet my child's needs.