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.