



**Treatment Facility: Student Re-Entry Plan**  
**Demographic Information**

Student Name: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

With whom does the student reside? \_\_\_\_\_

Emergency Contact 1:  
Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Emergency Contact 2:  
Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date of Release: \_\_\_\_\_ Facility Name: \_\_\_\_\_

Facility Contact Person: \_\_\_\_\_ Facility Phone Number: \_\_\_\_\_

School / Facility Communication Release Signed:                      Yes                      No

**Treatment Planning Information**

What are the recommended discharge directions/supports for the student?

What is the functional diagnosis level of function?

What is the DSM diagnosis? \_\_\_\_\_

When is the next follow-up appointment scheduled? \_\_\_\_\_

With whom is the next follow-up appointment scheduled? \_\_\_\_\_

School / Facility Communication Release Signed (circle):                      Yes                      No



Student Name \_\_\_\_\_

### **Student Behavior Information**

What escalates the problem behaviors?

What helps de escalate the problem behaviors?

List coping strategies with suggestions on how these can be supported in the school environment:

### **Clinical Information**

Medications the student is discharged on:

Medication side effects that may impede school function:

Medication Orders and parental consent if medication should be administered in school  
(circle) Yes No

Parameters to administer PRN medications as needed:

### **Administrative Information**

How would student & family like their absence to be explained (protect confidentiality)?

Are there any specific concerns considerations that may affect a student's academic performance?

Are there any specific concerns regarding the student's ability to maintain safety within the school environment?



Student Name \_\_\_\_\_

### Student Safety Plan

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Date of Plan: \_\_\_\_\_ Review Date of Plan: \_\_\_\_\_

Specialized Education Plan (Circle all that apply)

Gifted      Special Education      504      ELL

Student stressors and triggers:

Student coping strategies:

Safe place(s) for student:

School safety plan:

Is there a plan for home?      Yes      No

Persons needing a copy of the safety plan (circle all that apply):

Parent(s)      Student      Teacher(s)  
School Psychologist      School Counselor      Administrator  
Education Support Provider      Other: \_\_\_\_\_



Student Name \_\_\_\_\_

Participants in creating the plan:

Title	Name	Signature	Date

Distribution List:

- Parent(s)
- Student
- Court / Probation Services
- Administration
- Education Support Provider
- Guidance Counselor
- Main Office - Student File
- Student Services (where applicable)
- Other: