

CRISIS INTERVENTION CHECK LIST

_____ 1. **Two** members of the Crisis Team interviewed the Student*. The **Crisis Team** consists of:

* Student must remain under supervision at all times.

School Counselor
School Nurse
School Social Worker
School Psychologist
Student Assistance Counselor

School Administrators **cannot** substitute for one of the two Crisis Team Members

_____ 2. **Notified Principal and School Nurse and consult with Child Study Team Case Manager if applicable.**

_____ 3. **Suicide Ideation**

a. _____ referred to **Mental Health Professional** for assessment.

_____ 4. **Homicidal Ideation**

a. _____ referred to **Mental Health Professional** - discipline policy runs concurrent with crisis intervention.

b. _____ a student **Resource Officer** was notified.

WVHS – Det. Ray Caronia – 973-317-2207

WHHS – Det. Eugene Foster – 973-317-2051

_____ 5. **Release of Information** was signed by parent (when possible).

_____ 6. Parent was informed:

Student must be seen within **24 hours**.

Student must return with **written clearance**.

Parent and student must report to the Health Office upon return.

_____ 7. **Crisis Team** assisted parent in **obtaining appointment** for student within **24 hours**.

A **Crisis Team Member telephoned** the provider to inform them of the situation.

Chilton Hospital E.R. Crisis Screening

973-831-5430 Fax - 973-907-1055

St. Joseph's Hospital Pediatric E.R.

973-754-4901 (Paterson)

_____ 8. Parent was provided with the following paperwork:

1. POST CRISIS INTERVENTION DIRECTIONS FOR PARENT

2. RE-ADMIT LETTER FOR PRIVATE PROFESSIONAL *(hospitals use their own discharge form)

3. Mental Health RESOURCES

_____ 9. The Building Principal e-mailed their Director, informing them that a crisis intervention was taking place – please include grade & only student's initials. (cc: Mary J. Landowski, R.N.).

_____ 10. **CRISIS SUMMARY** was completed. The **original** goes to the School Nurse and a copy forwarded to: MaryJ. Landowski, R.N., Supervisor of Health Services – Board Office

Office - 973-317-2198

_____ 11. A member of the Crisis Team has been designated to provide appropriate follow-up for the student.

Please note: Crisis Intervention paperwork is to be utilized by Crisis Teams exclusively.

WAYNE TOWNSHIP PUBLIC SCHOOLS
CRISIS INTERVENTION SUMMARY FORM

SCHOOL:	DATE OF INCIDENT:
STUDENT'S NAME:	GRADE:
ADDRESS:	DATE OF BIRTH:
PHONE NUMBER:	check: GE <input type="checkbox"/> SE <input type="checkbox"/>

1. Crisis Case Manager's Name/Title:	
2. Crisis Team Member Name/Title:	

- ***PER CRISIS POLICY – 2 members must interview***

Summary of the incident (ie., basic description of events leading to crisis intervention including how initially reported, concerning actions of students, etc.):

WAYNE TOWNSHIP PUBLIC SCHOOLS
CRISIS INTERVENTION SUMMARY FORM

Chronological List of Contacts (ie., who was involved; what intervention measures were taken; what additional individuals were contacted; if parent report to school; etc.):

Recommendations to parent (please “X” all that apply & indicate referrals made):

Recommendations/Action Taken	Name of Referral
Obtain outside mental health assessment – referrals:	
Explore private counseling – referrals:	
No recommendations for assessment or counseling	

Action Taken	Name of Notified	Notified by:	Date:
** Parent/Guardian Notified			
CST Case Manager Consulted			
SRO Notified (Homicide Ideation)			

**** Parent/Guardian should always be notified.**

OTHER:

*Completed original copy – to School Nurse
 Copy – to Mary J. Landowski – Supervisor of Health Services – Board Office*

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Post Crisis Intervention Directions for Parents

To insure that your child can successfully return to school and resume his/her normal routine, the crisis team and building administrator have determined that, per District Policy, your child must be seen by a mental health professional.

In order for your child to be cleared to return to school, you must complete the following:

1. Bring your child for an evaluation *within 24 hours of notification*.
 - a. You may bring your child to a professional, meeting the specified criteria, with whom you know or use one of the individuals suggested by the school.
2. Have the professional provide signed, written documentation of confirmed visit and any recommendations and/or treatment.
3. On the day your child is due to return to school, **bring your child, along with the documentation signed by a mental health professional directly to your child's school nurse for clearance.**
 - a. Your child **will not** be able to re-enter his/her classes unless he/she is cleared by the school nurse.

If you have any questions or have difficulty obtaining an evaluation you can contact

_____ at your child's school at _____
Staff Name/Title Contact Number



Township Public Schools

I am aware that the Wayne Township Public Schools has done a crisis intervention with

Student's Name: _____

on: _____
Date

regarding:

As a follow-up I have seen and assessed him / her and deem that he / she

is

is not

physically and mentally able to return to school on _____.
Date

Listed below (if any) are my recommendations for follow-up care:

Signature of Mental Health Professional

Stamped or Printed Name

Date

Contact Number

This form must be completed by a mental health professional and be presented to the school nurse by the parent prior to a student's readmission to school.



**Consent for
Release and Exchange of Confidential Information**

Student Name	
Home Address	

Telephone	
Student's School	

I hereby authorize the release and exchange of confidential information and records concerning my child between:

Name of Provider	Title of Provider

and the School Nurse or member of the Wayne Township Public Schools' Crisis Team.

The exchanged information will be used to assist with school reentry, academic program planning and ongoing consultation.

Parent/Guardian Signature

Date

Printed Name