New Hanover County Schools
Parental Release for a Suicidal /Threatening Harm to Others Student

Student: _____ **Meeting Date:** _____

Parent/Guardian_____**Contact Number:**_____

You are being contacted regarding your child's crisis. A Student Support Services staff member has met with him/her and there is concern that he/she is at risk for _____suicide or _____harming others.

A licensed mental health provider must assess the student for safety. This could be your child's current mental health provider/therapist, a school-based mental health therapist (including those at the W.H.A.T. clinic (if the student is already a client or with written parent/guardian permission), Mobile Crisis or other Emergency resource (see Attachment C). **Please take a copy all forms provided to you by the school today to give to the mental health provider of your choice**.

In addition, the following recommendations should be considered:

- Remove access to all guns, knives, medications, belts, and other objects that have the potential to be lethal or cause harm. Secure (lock up) or remove from home.
- Maintain constant visual contact with the student (don't go to sleep or consume alcohol or medications that could impair your ability to act). Family members may be needed to assist in supervision during the night or at times the child would be typically alone.
- Call 911 or go to Emergency Room as needed.

It is require that you schedule a meeting with school personnel upon clearance to return to school:

Contact:_____

Parent/Guardian Signature Date

New Hanover County Schools
Provider Release for a Suicidal /Threatening Harm to Others Student

*Must be completed by a licensed mental health professional OR Qualified Professional (QP) **in direct consultation with a licensed mental health professional** prior to return to school. Examples of licensed mental health professionals include, but are not limited to: Licensed Clinical Social Worker, Licensed Professional Counselor, Psychologist. Please note, a general practitioner or pediatrician **is not** a licensed mental health provider)

Student: _____Date/Time of Evaluation:_____

Agency: _____ Phone: _____

Agency Address:_____

1. Do you feel that the student is an immediate danger to self or others? Please explain.

_____

_____

_____

2. Is the student safe/prepared to re-enter school or should a transitional re-entry plan be established?

_____

_____

_____

3. What additional supports/accommodations will need to be in place for the student to successfully manage the school day?

_____

_____

_____

*Please attach Student Safety Plan, if completed.

Signature of Licensed Mental Health Professional OR Designee in direct consultation with a

Licensed Mental Health professional:_____

Printed Name_____

Date: _____Title_____

Name of Licensed MH Professional consulted (when applicable):

_____ Title_____