BONNIE CONE CLASSICAL ACADEMY

Individualized Mental Health Care Plan

Campus _____ School Year 20_____/20_____

Active 504 or IEP on file: ____Yes ____No If Yes, a 504 Coordinator needs to be present.

If no, is an IEP or 504 meeting required? ____Yes ____No

Does the student ride the bus? ____Yes ___No

If Yes, has transportation been notified: ___Yes ___No

Copy of plan distributed to teachers: ____Yes ____No

Name of Student _____

Age _____ DOB _____ Grade _____ Date _____

Parent(s)/Guardian(s): _____

Phone #s: Home: _____ Work: _____ Cell: _____

Email: _____

In case Parent(s)/Guardian(s) cannot be reached, call _____

at _____. Relationship to student: _____

Medical Provider: _____

Phone: _____ Address: _____

Medical Diagnosis: _____

Medication Instructions: _____

In Patient (Length of stay): _____ Emergency Hold (Length of stay): _____

Crisis Hotline Follow up: _____ Other: _____

___ ***I/We, decline to provide any information to BCCA in regard to my student about their recent hospitalization. I/We understand that by not providing discharge care information, BCCA is limited in its ability to provide for the well-being of my student if further issues should arise.***

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Individualized Mental Health Care Plan

Teacher Copy:

Active 504 or IEP on file: ____Yes ____No

Name of Student _____

Age _____ DOB _____ Grade _____ Date _____

Parent(s)/Guardian(s): _____

Phone #s: Home: _____ Work: _____ Cell: _____

Email: _____

In case Parent(s)/Guardian(s) cannot be reached, call _____

at _____. Relationship to student: _____

Overall Assessment Data (General assessment of student entering at this time):

__ Excited __ Happy __ Neutral __ Anxious __ Scared __ Sad __ Other: _____

Conditions Needing Vigilance at School:

__ Safety (sharp objects, etc.): _____

__ Anxiety/Panic attacks (tools/techniques): _____

__ When to Call Parent (Note if related to anxiety/panic attack; after 2 visits to the Health Office, will call parent for pick up): _____

__ De-escalation techniques: _____

__ Other: _____

Instructions from Provider to keep student safe at school: _____

_____

_____

_____

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What the Parents Will Do:

__ Communicate with Teacher and Health Aide

__ Bring in relaxation tools/medication as needed

__ Other: _____

What the School/Health Staff Will Do:

__ Communicate with Parents and Teachers

__ Allow rest, time in Health Office, parameters: _____

__ Treat student per plan

__ The school will not be able to provide certified counseling.

__ Other: _____

What the Student Will Do:

__ Communicate with Teacher, Health Aide and Parents

__ Other: _____

__ Other: _____

__ Other: _____

Additional Information (See Assistant Director for Academic Needs):

__ Need schedule changes

__ Go to half days

__ Help with school work/ Teacher Intervention

__ Other: _____

I agree to follow the above plan and remain safe at school _____
Student Signature

Parent Signature: _____ Health Staff Signature: _____
Assistant Director: _____ 504 Coordinator: _____
Approved by: _____
Health Program Representative