PORT TOWNSEND SCHOOL DISTRICT 2145 APP 4

SAFETY PLAN

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that crisis may be developing

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity).

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____
4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. 24 hr. Crisis Line (local)……. 1-888-910-0416
2. 24 hr. Crisis Text Line……. Text "HEAL" to 741741
3. Suicide Prevention Lifeline…… 1-800-273-TALK (8255)
4. The Coffee Oasis Text Line……. Text "HELP" to 360-377-5560
5. Trevor Project (LGBTQ+)……..Text "START" to 678678
   Call 1-866-488-7386
6. MY3 App – Helps you stay connected when you are having thoughts of suicide
7. TeenLine……Text "TEEN" to 839863 between 6 – 9 pm
8. Local Emergency Service_____
   Emergency Services Address _____
   Emergency Services Phone _____

Making the environment safe:

1. _____
2. _____

From Stanley, B. & Brown, G.K. (2011). Safety Planning Intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice. 19, 256-264*

RE-ENTRY STUDENT SUPPORT AND SAFETY PLAN

Student Name:	School:	Grade:	Date:

☐ Documentation received that student is safe to return to school (suggested, not required)
Medical/Mental Health Provider Name: _____

General Supports:
☐ Student Resource Document
☐ Student Safety Plan Document

School Support Options:
☐ Designated safe place at school: _____
☐ Alert staff & teachers on a need-to-know-basis (including list of staff below)
☐ Late arrival/early dismissal
☐ Other schedule changes: _____
☐ Update existing 504/IEP, if applicable
☐ Referral to Student Support Team
☐ Check-ins:
Frequency _____ End Date: _____
With:
☐ Administrator ☐ School Counselor ☐ SRO ☐ Dean
☐ Other: _____
☐ Student will seek out the following staff:
1. _____
2. _____
3. _____
4. _____
5. _____

Family/Home Options:
☐ Safety measures at home
☐ Increase supervision
☐ Pursue mental health services: _____
☐ Other: _____

Communication between school and providers:
☐ ROI obtained
☐ Initial contact with provider on (date)_____
☐ Continued follow up with provider needed

Comments:

Student Signature:_____Date:_____
Parent/Guardian Signature:_____Date:_____
Form Completed By:_____Date:_____
Name Position

Plan Review by _____

Copies to: ☐ Parent/Guardian ☐ Student ☐ Mental Health/Medical Provider

Original copy will be kept in student confidential file in school counseling office