

Student Re-Entry Guide

*Asterisk denotes drop-down list

Student Information:		
Student Name:	ID:	Date:
School: *	Grade: *	

Meeting Information:			
Meeting Scheduled for:	<i>Date</i>	<i>Time</i>	Meeting Location:

Initial Checklist			
	Yes	No	
Release of Information(s) Completed?	<input type="checkbox"/>	<input type="checkbox"/>	Provider(s):
Did Student Receive In-Patient Services?	<input type="checkbox"/>	<input type="checkbox"/>	Provider: Placement: (Admitted Date) to (Discharge Date)
If yes, was provider contacted?	<input type="checkbox"/>	<input type="checkbox"/>	In-Patient Client Code:
Is Student Receiving Outside Counseling?	<input type="checkbox"/>	<input type="checkbox"/>	Provider:
If yes, was provider contacted?	<input type="checkbox"/>	<input type="checkbox"/>	
If no, has referral been completed if necessary?	<input type="checkbox"/>	<input type="checkbox"/>	Provider: Date of referral:
Is Student receiving services through a 504 Plan or IEP?	<input type="checkbox"/>	<input type="checkbox"/>	Which:
Team Members Invited to Meeting?	<input type="checkbox"/>	<input type="checkbox"/>	Invited: Administrator, Counselor, Parent, Student, Mental Health Provider (if applicable), other support staff (if applicable), CPS (if applicable)
Is a 504 Plan Referral Needed? 504 Procedural Handbook	<input type="checkbox"/>	<input type="checkbox"/>	If yes, who will initiate referral:
Student Initial Support Plan Needed?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date completed:
Student Safety Plan Needed?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date completed:
Student Supervision Plan Needed?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date completed:
Teacher(s) and Support Staff Notified of Initial Support Plan, Student Safety Plan, and/or Temporary Support Plan (if appropriate)	<input type="checkbox"/>	<input type="checkbox"/>	Staff responsible for notification:

(Please provide building administrator with a copy of checklist following the meeting)

Re-Entry Meeting

Meeting Information:	
Meeting Date:	Meeting Time:

Meeting Participants:		
Name:	Role:	If "Other" please identify
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	*	
	*	
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	*	
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Information Gathering:
Student Input
<i>Do you have concerns about returning to school?</i>
<i>Who do you want to know about your absence?</i>
<i>What information is okay to tell them?</i>
<i>Who is a teacher or other adult in school you feel like you can go to if needed?</i>
<i>How can your school team best support you?</i>
Family Input
<i>Do you have any academic concerns?</i>
<i>Do you have any social emotional and/or mental health concerns?</i>
<i>Do you have any additional comments or concerns?</i>
School Input
<i>Do you have any academic concerns?</i>
<i>Do you have any social emotional and/or mental health concerns?</i>
<i>Do you have any additional comments or concerns?</i>
Provider Input and Recommendations (if available):

Follow up meeting scheduled for:
If not scheduled, please explain: