Clear Form

Miami-Dade County Public Schools

Mental Health Team Plan

School Name: _____ Date: _____

Student Name: _____ ID#: _____

Address: _____ Phone #: _____

Grade: _____ DOB: _____ Age: _____

Legal Guardian (s): _____ _____

Nature of Crisis

☐ **Requested by:**

- ☐ Student
- ☐ Teacher
- ☐ Administrator
- ☐ Counselor
- ☐ Social Worker
- ☐ Mental Health Coordinator
- ☐ Other: _____

☐ **Type of Incident:**

- ☐ Verbal threat(s)
- ☐ Physical threats(s)
- ☐ Aggressive behavior
- ☐ Suicidal ideation/behavior
- ☐ Homicidal ideation/behavior
- ☐ Bizarre/unusual behavior
- ☐ Depressed/Withdrawn
- ☐ Possession of weapon
- ☐ Ingestion
- ☐ Neglect
- ☐ Illness
- ☐ Anxiety/Panic Attacks

Summary of Mental Health Screening:

_____

_____

_____

_____

Mental Health History

Outpatient Services	Agency	Provider Name	Active	Date of last Visit
Case Manager			Y ☐ N ☐	
Therapist			Y ☐ N ☐	
Psychiatrist			Y ☐ N ☐	
(Other/ Additional)			Y ☐ N ☐	

Inpatient Services	Agency / Hospital	Date of Service	Presenting Problem
Baker Act			
Psychiatric/Psychological Care			
(Other/ Additional)			

Actions Taken:

- □ Developed safety plan
- □ Contacted parent/caregiver
- □ Met with parent/caregiver
- □ Alerted/Referred to_____
- □ Provide continuous supervisor
- □ Alerted/Referred to School Resource Officer/Police
- □ Complete Professional Certificate (Baker Act)
- □ Arranged follow-up (specify)
- □ Additional Contacts (specify)

Other _____

Outcome of Actions Taken:

_____

_____

_____

_____

Description of Plan:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Mental Health Team:

School Site Administrator: _____

Parent: _____

Teacher: _____

Counselor: _____

School Psychologist: _____

School Social Worker: _____

Mental Health Coordinator: _____

Contracted Agency: _____

Other: _____