NORWOOD PUBLIC SCHOOLS

BEHAVIORAL HEALTH

Re-Entry to School Referral

Student Name: _____ **DOB: _____**

School: _____ **Grade: _____**

Anticipated Date of Return to School: _____

Primary contact person at school: _____

Secondary contact person: _____

Phone: _____ **Email: _____**

THIS SECTION IS ONLY TO BE FILLED OUT BY A PHYSICIAN/THERAPIST
PLEASE TYPE OR PRINT

Reason for hospitalization/placement: _____

Functional Diagnosis: _____

DSM Diagnosis (optional): _____

Behavioral Health Concerns: _____

_____

_____

Maladaptive behaviors: _____

_____

_____

Triggers: _____

_____

Coping Strategies/ Interventions: _____

_____

_____

Relaxation/de-escalation techniques preferred /interventions: _____

_____

_____

Medication(s): _____

Date(s) Started: _____

Side Effects: _____

What should staff/students be told about the reason for the student's absence:

_____

_____

_____

Factors that may affect academic performance:

_____

_____

_____

_____

_____

After care plan/follow-up:_____

Physician/therapist signature _____ Date _____
Print Name: _____

I hereby authorize _____ of _____
Name *Address/Organization*

and _____of _____
Name *Norwood School Affiliation*

to release information concerning _____ to one another.
Name of Student

I also hereby release both parties from all liability and all claims pertaining to the disclosure of this information.

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____

Phone: _____ Email:_____

Norwood Public Schools person receiving this form: _____
Signature