Hemet Unified School District
Risk Assessment
RE-ENTRY TO SCHOOL

Student Name: _____ DOB: _____

School Psychologist/Counselor: _____ School: _____

Parent/Guardian: _____Phone: _____

Below To Be Completed by Licensed Mental Health Professional

Mental Health Assessment: Date: _____ Time: _____. At the time of this assessment:

_____ was not a danger to self or others.
_____ was not gravely disabled.
_____ may return to school psychologist or health office on __/___/___ date.

***Is safe to return to school on (date):** _____
Treatment Facility:_____ Mental Health Professional's Name and title: _____
Dates of Hospitalization/treatment:_____

Diagnosis: _____

Medications*: _____ **If needed at school, request separate form*

Restrictions/Accommodations: ☐ NO ☐ YES, If yes, please specify:

_____

_____

_____

Follow-up Recommendations for psychotherapy: _____

_____

_____

_____

There was reasonable cause to believe that this student had emotional difficulties and/or was a danger to him/herself or others or gravely disabled and in need of care and treatment. An evaluation of the student named above by the examining clinician has concluded that the student is mentally competent **at the time of his/her assessment** and is capable of functioning in the school environment without being a danger or causing disruption to him/herself or others.

Clinician Signature _____ Date _____

Clinician Name _____ Phone _____

********Student to report back to the school psychologist/ health office upon returning to school*****

Parent Signature _____ Date _____

PARENT AUTHORIZATION: I give my permission for school personnel and physician to exchange information regarding my child.