PARENT NOTIFICATION OF EMERGENCY

As a part of the Nash-Rocky Mount Public Schools protocol developed by Student Services for students exhibiting crisis behavior or making suicidal statements, __________________________ received counseling and was assessed for risk of suicidal attempt. Based on this assessment, your child is determined to be at risk for suicide.

As part of the school plan, I asked your child to agree to a “no harm” contract and made arrangements to meet on the next school day following our conversation or their next day present. Your child was also informed that I am required to contact you if I have any indication that his or her safety may be in jeopardy. It is extremely important to make sure that you monitor your child outside of the school setting at this delicate state.

________________________________________
School Counselor/Social Worker & Date

________________________________________
Contact Number

____ Discussed w/ parent via phone/letter    ______ Discussed w/ parent in person

☐ I have been advised that my child appears to be in a state of psychological emergency (danger of hurting self/suicidal ideation.)

☐ I have been further advised that I should seek psychological/psychiatric consultation as soon as possible/immediately.

☐ I have been provided with a list of agencies and emergency numbers.

☐ I have been informed of home safety and supervision.

☐ I understand that the school district is not responsible for the provision of or payment for these services, but is alerting me to this emergency just as they would inform me of any health problem.

☐ I understand a re-entry meeting must occur upon my child’s return to school.

________________________________________   _____________________________   ___________________________
Parent/Legal Guardian                      Parent/Legal Guardian                      Date

________________________________________   _____________________________   ___________________________
School Counselor/Social Worker            School Counselor/Social Worker            Other School Staff Member

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See by Outside Mental Health Professional:
(to be completed by mental health professional, school counselor, or school social worker)

________________________________________   _____________________________   ___________________________
Agency/MH Professional                      Date seen                              Signature