PORT TOWNSEND SCHOOL DISTRICT
SAFETY PLAN

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that crisis may be developing

1. ________________________________________________________________
2. ________________________________________________________________
3. ________________________________________________________________

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity).

1. ________________________________________________________________
2. ________________________________________________________________
3. ________________________________________________________________

Step 3: People and social settings that provide distraction:

1. Name_____________________________________ Phone___________________
2. Name_____________________________________ Phone___________________
3. Place____________________________________________________________
4. Place____________________________________________________________

Step 4: People whom I can ask for help:

1. Name_____________________________________ Phone___________________
2. Name_____________________________________ Phone___________________
3. Name_____________________________________ Phone___________________

Step 5: Professionals or agencies I can contact during a crisis:

1. 24 hr. Crisis Line (local)............... 1-888-910-0416
2. 24 hr. Crisis Text Line...................... Text “HEAL” to 741741
3. Suicide Prevention Lifeline............. 1-800-273-TALK (8255)
4. The Coffee Oasis Text Line............. Text “HELP” to 360-377-5560
5. Trevor Project (LGBTQ+)............... Text “START” to 678678

6. MY3 App – Helps you stay connected when you are having thoughts of suicide
7. TeenLine.................................Text “TEEN” to 839863 between 6 – 9 pm
8. Local Emergency Service
   Emergency Services Address ___________________________________________
   Emergency Services Phone _________________________________________

Making the environment safe:

1. ________________________________________________________________
2. ________________________________________________________________


April 2021
RE-ENTRY STUDENT SUPPORT AND SAFETY PLAN

Student Name: [ ] School: [ ] Grade: [ ] Date: [ ]

☐ Documentation received that student is safe to return to school (suggested, not required)
Medical/Mental Health Provider Name: ____________________________

General Supports:
☐ Student Resource Document
☐ Student Safety Plan Document

School Support Options:
☐ Designated safe place at school: ____________________________
☐ Alert staff & teachers on a need-to-know-basis (including list of staff below)
☐ Late arrival/early dismissal
☐ Other schedule changes: ____________________________
☐ Update existing 504/IEP, if applicable
☐ Referral to Student Support Team

☐ Check-ins:
  Frequency ____________________________ End Date: ____________________________
  With:
  ☐ Administrator ☐ School Counselor ☐ SRO ☐ Dean
  ☐ Other: ____________________________

☐ Student will seek out the following staff:

  1. ____________________________
  2. ____________________________
  3. ____________________________
  4. ____________________________
  5. ____________________________

Family/Home Options:
☐ Safety measures at home
☐ Increase supervision
☐ Pursue mental health services: ____________________________
☐ Other: ____________________________

Communication between school and providers:
☐ ROI obtained
☐ Initial contact with provider on (date) ____________________________
☐ Continued follow up with provider needed

Comments:

____________________________________________________________________________________

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____________________________________________________________________________________

Student Signature: ____________________________ Date: __________________
Parent/Guardian Signature: ____________________________ Date: __________________
Form Completed By: ____________________________ Date: __________________

Name: __________________ Position: __________________

Plan Review by ____________________________________________

Copies to: ☐ Parent/Guardian ☐ Student ☐ Mental Health/Medical Provider

Original copy will be kept in student confidential file in school counseling office