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Sea Star Children's Programs

Attention School Social Workers, Family Counselors & Guidance Counselors

The Trustbridge Bereavement Centers are pleased to offer children's bereavement grief groups, which may be provided at your school at no charge.

How do I begin a group at my school?

1. Identify three or more students with bereavement needs. Call 954.267.3875 or email bereavementadmin@trustbridge.com and ask to be placed on the list of schools requesting services.
2. A school bereavement counselor will contact you to schedule the group. Completed consent and assessment forms must be received before the first group meets. Fax the forms to 561.273.2267. Additional students will not be admitted into the group after the start date. *Please note that if suicidal ideations are checked on the assessment, then record what intervention has been provided before faxing it.
3. Please educate the school bereavement counselor on your procedures for emergency codes.
4. Notify teachers of the dates and time the group will be held, and encourage them to support the students' participation in group. Reserve a quiet place for group to be held with space for group writing activities. The groups are offered on a first-come, first-serve basis.

The group meets weekly for 1 hour for 6 consecutive weeks, and ½ hour for 6 weeks for kindergarten.

How to identify youths and set up a group: A student who may be included in the bereavement (Sea Star) group has had a family member or friend die. The group members should be of similar age. We are available to lead 2 groups if there is a wide age-range difference, large number of students, or if the students' needs vary.

If you are interested in training or additional information for your students, please call 954.267.3875.

We look forward to working with you towards helping students develop coping skills and knowledge to progress on their healing journey.

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Sea Star Children's Programs

Bereavement Consent and Assessment
School Program

GENERAL INFORMATION

Youth's Name: _____ Date of Birth: _____ Age: _____

Home/Mailing Address _____ _____
Street *Apt.*

_____ _____ _____
City *State* *Zip*

Phone #: Home _____ Work _____ Cell _____ Email _____

School _____ Grade _____ Special Placement _____

RELATIONSHIP AND HISTORY

Name of Deceased _____ Relationship to Youth _____

Cause of Death _____ Date of Death _____

How did child get along with the deceased? _____

Was the death expected? _____ How long was the person ill? _____

Was the deceased a hospice patient (which one)? _____

Was the death sudden? _____ Was there violence/trauma (describe)? _____

Was the youth present at the moment of death (describe reaction)? _____

Did youth attend the memorial/funeral/graveside services? _____

Previous losses, traumas, or deaths the youth has experienced (divorces, moves, loss of pet, witness to abuse, etc.) _____

Who currently resides in the family home? _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Other siblings/close family members who do not reside in the home? _____

Family relationship concerns: _____

PRESENTING CONCERNS (Check all items that apply to youth)

_____ No changes or difficulties _____ Not showing feelings _____ Stays by self alone; isolates

_____ Thoughts of suicide (describe child's actions and explain how child was helped) _____

_____

_____ Hurting self or others (describe)

_____ Problems in school (describe)

_____ Acting-out behaviors (describe)

_____ Personality changes (describe)

_____ Sleep or eating problems (describe)

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PRESENTING CONCERNS (Check all items that apply to youth) continued

List medications child is taking and reason: _____

_____

List counseling/religious services and providers previously or currently working with child: _____

_____

What would you like your child to achieve by participating in counseling? _____

_____

What are your child's interests or activities in the community or after school?_____

_____ _____

Parent/Legal Guardian Signature *Date*

Confidentiality Statement: Client information will not be released without the written consent of the parent/ legal guardian. Confidentiality is maintained according to HIPAA guidelines. Art work or journaling that a child would like to share may be copied or photographed. Suicidal or homicidal plans and suspected child abuse are reported as required by law. **PLEASE NOTE INFORMATION IS EXCHANGED WITH THE SCHOOL GUIDANCE COUNSELOR TO MANAGE CASE AND ENSURE CONSISTENT CARE.**

I, _____ give authorization for _____
(Name of parent or guardian) *(Name of child)*
to attend counseling services offered by Trustbridge.

_____ _____

Parent/Legal Guardian Signature *Date*

I, _____ , am 18 years of age or am an emancipated minor, and am authorizing Trustbridge to provide counseling services to me.

_____ _____ _____

Client Signature *Date* *Student ID#*

Witnesses:

_____ _____

School/Agency Signature and Date *Trustbridge Staff Signature and Date*

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