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.
# 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?

- **Name:** ____________________________  |  **Relationship:** ______  |  **Age:** ______

### FAMILY relationship concerns:

**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? 

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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 __________________________ 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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