Exhibit A

STUDENT CRISIS INTERVENTION TEAM QUESTIONNAIRE
Passaic Public Schools
In conjunction with St. Joseph's Hospital
Phone: 973-754-2230 Fax: 973-754-3721

Date: _____

Student Name: _____ DOB: _____

Parent/Guardian Name: _____Phone: _____

Address: _____

Please complete this questionnaire to the best of your ability. You should have this information available if you have to contact St. Joseph's Hospital. Use the following questions to aid in the determining if this student is at **IMMINENT RISK** for harming himself/herself. If the answer is yes, contact the parent/guardian. Have them come to the school or proceed directly to St. Joseph's Hospital.

DO NOT LET THIS STUDENT OUT OF YOUR SIGHT. He/she must remain under adult supervision at all times. If the student's refuses to answer questions, please indicate so on the questionnaire.

1. **How did the student come to your attention? (please circle)**
   a. Teacher referral
   b. Written communication
   c. Student referral
   d. Self referral
   e. Other _____

2. **Why was this student referred? Please write brief summary.**
   _____
   _____
   _____

3. **Why does this student feel he/she was referred? Please write brief summary.**
   _____
   _____
   _____

4. Is the student experiencing any of the following symptoms? Please check all applicable areas

a. Sleeplessness or excessive sleep ☐
b. Break with boyfriend/girlfriend ☐
c. Disturbances in appetite ☐
d. Depressed mood most of the time ☐
e. Death or illness of close family member or friend ☐
f. Auditory /visual hallucinations ☐
g. Difficulty concentrating or paying attention ☐
h. Recurring or obsessive thoughts ☐
i. Change in grooming habits ☐
j. Increase in absences ☐
k. Sudden mood swings or changes ☐
l. Other changes in behavior noted by school personnel ☐
m. Change in status or household ☐

5. What is this student's affect? (please check)

a. Flat ☐
b. Appropriate ☐
c. Depressed ☐
d. Giddy ☐
e. Tearful ☐
f. Angry ☐

6. Does this student have specific intent? (please check)

a. YES_____ b. NO_____

7. What is that intent?

_____
_____
_____

8. Has this student every attempted suicide in the past?

YES _____ NO _____

9. If so, how long ago was the attempt and what did he/she do? Please be specific.

_____
_____
_____

10. Does this student have a support system (please check all applicable):

a. at home YES _____ NO _____
b. at school YES _____ NO _____
c. in the community YES _____ NO _____

11. **Is this student currently seen for counseling either in school or in the community?**

YES _____ NO _____

If yes, by whom and how often?

_____

12. **Is this student taking medication? (please check)**

YES _____ NO _____

If the student is taking medication, what is the medication and did he/she take the medication today? Please be specific.

_____
_____
_____

13. **Has the parent/guardian been contacted? (please check)**

YES _____ NO _____

14. **Will the parent be able to come to school?**

YES _____ NO _____

Or meet at hospital?

YES _____ NO _____

15. **Is this child involved with the Child Study Team?**

YES _____ NO _____

If yes, please identify Child Study Team Member and/or Case Manager:

_____

16. **Do have any other pertinent information to add?**

_____
_____
_____
_____
_____

17. **If you contacted St. Joseph's Hospital Crisis, with whom did you speak with?**

_____
_____
_____

If you make the call to St. Joseph's Hospital, you must fax this questionnaire.