



*The School Board of Brevard County, Florida*  
**MENTAL WELLNESS SUPPORT REQUEST – FORM 1**

**Date:** \_\_\_\_\_

**Name of Student:** \_\_\_\_\_ **Student Number** \_\_\_\_\_

**Form completed by:** \_\_\_\_\_

**Relationship to Student:**  Teacher/Staff       Parent/Legal Guardian       Friend       Self

**Date of Parent/Legal Guardian Contact:** \_\_\_\_\_

**Outcome of Parent/Legal Guardian Contact:**

Please complete age appropriate checklist to the best of your knowledge. Information gathering will be on-going.

[Hyperlink forms Here](#)

**How long have you observed this change/concern?**

- Less than 30 days
- More than 30 days

**How often does this occur?**

- Daily
- Weekly
- Monthly

**What are/were interventions and supports that are/have been in place? (if known)**

In School: \_\_\_\_\_

Outside of School: \_\_\_\_\_

**Return completed form to School Counselor or School Social Worker**