

Parent/Caregiver Transition Readiness Tool

What is the goal of the tool/resource?

To assess parent/caregiver knowledge of youths' transition readiness skills and engage parents/caregivers to work with their youth to set behavioral health priorities, address self-care skill needs to prepare them for adult health care after high school, and prepare them to independently access behavioral health and wellness services.

Who is the audience?

Parents/caregivers of youth in high school.

Who should facilitate this tool/resource?

Someone who has an ongoing, trusted relationship with a student and has behavioral health knowledge and the ability to refer to behavioral health services, if needed. This can include school mental health providers, school-based health center staff, school psychologists, professional school counselors, and school social workers.

How should the staff team member facilitate this tool/resource?

Staff team members could offer the transition readiness tool annually to be completed by the parent/ caregiver preferably at the same time as the youth is completing the transition readiness tool so the parent/caregiver and youth can begin a conversation about transition, discuss findings, and compare answers. This can be emailed to parents/caregivers or handed out during parent sessions/ meetings. The staff team member can offer education and resources to the parent/ caregiver to share with the youth on needed skills identified through the transition readiness tool.

Parent/Caregiver Transition Readiness Tool

Directions: Please fill out this form to help us see what your child already knows about their mental health and how to continue caring for their mental health after high school. After you complete the form, you can ask your child to share their answers from their completed form, and you can compare them. Your answers may be different.

Name: _____

Your Child's Name: _____

Date Completed: _____

On a scale of 0 to 10, please check the number that best describes how your child feels now.

How likely is your child to want to continue therapy or counseling after high school?

0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10
not _____ very

How confident is your child in their ability to find therapy or counseling after high school?

0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10
not _____ very

MY CHILD'S MENTAL HEALTH *Please check the box that applies to you now.*

	NO	THEY WANT TO LEARN	YES
My child has concerns about their mental health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child can name their learning differences, disability, medical, or mental health diagnosis (examples: asthma, diabetes, ADHD, anxiety, depression).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child can explain their learning differences, disability, medical, or mental health needs and symptoms to others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child has someone they can talk to if they have a problem.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows what helps their mental health needs and symptoms.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows what stresses them out and how to avoid or cope with it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child know signs of when they are going into crisis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows what to do in case they are in crisis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ACCESSING MENTAL HEALTH SERVICES *Please check the box that applies to you now.*

	NO	THEY WANT TO LEARN	YES
My child knows how to connect with mental health services at school if needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows how to connect with mental health services in the community if needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows how to make their own therapy or counseling appointments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child has a way to get themselves to their therapy or counseling appointments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows who to call for help their therapist's or counselor's office is closed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows that when they turn 18, I will not have access to their health records, unless they allow it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows when they need to get their own health insurance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows how to find information to sign up for health insurance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child carries or has a photo of important health information with them every day (insurance card, emergency contact information, medication(s) list).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child has a pediatrician or other primary care provider.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows or can find the number of their pediatrician or other primary care provider.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If your child takes psychiatric medication, please continue.

PSYCHIATRIC MEDICATION *Please check the box that applies to you now.*

	NO	THEY WANT TO LEARN	YES
My child knows the name(s) of their medication(s).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows why they take medication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows when to take their medication each day.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows how to refill their medication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child knows the possible side effects of their medication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>