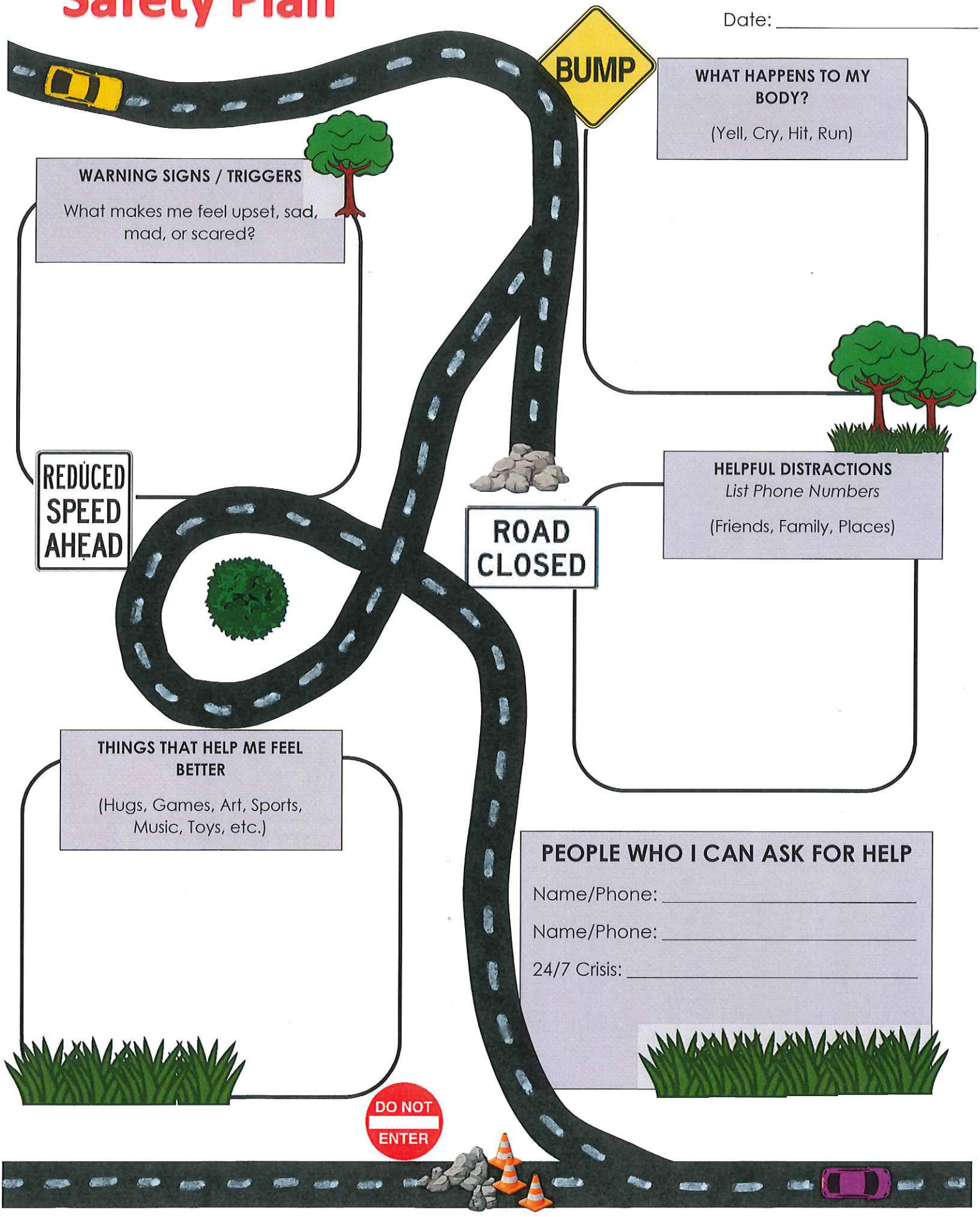
Safety Plan

Name: _____

Date: _____



WARNING SIGNS / TRIGGERS

What makes me feel upset, sad, mad, or scared?

WHAT HAPPENS TO MY BODY?

(Yell, Cry, Hit, Run)

HELPFUL DISTRACTIONS

List Phone Numbers

(Friends, Family, Places)

THINGS THAT HELP ME FEEL BETTER

(Hugs, Games, Art, Sports, Music, Toys, etc.)

PEOPLE WHO I CAN ASK FOR HELP

Name/Phone: _____

Name/Phone: _____

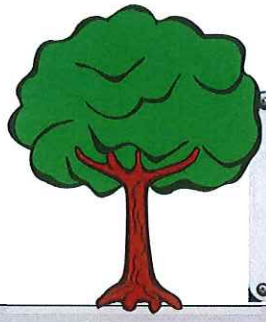
24/7 Crisis: _____

SIGNS THAT I'M DOING WELL ☺

THINGS MY FAMILY DOES TO KEEP MY HOME SAFE

(locked boxes, knives out of reach, routine Rx)

WAYS TO CELEBRATE SUCCESS



MY TEAM & PHONE NUMBERS

Individual Therapist: _____

Doctor / Psychiatrist: _____

Other: _____

(care coordinator – ICC, family partner, therapeutic mentor, in-home therapy)