

PHYSICAL RESTRAINT/SECLUSION INCIDENT RECORD<sup>1</sup> and DEBRIEFING REPORT

A. Student Information		School:	
Name:	UID#:	Date of Birth:	Grade:
<input type="checkbox"/> IEP* <input type="checkbox"/> 504 Plan <input type="checkbox"/> In referral process	Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No  Race (check all that apply): <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian/Pacific Islander	English Language Learner: <input type="checkbox"/> Yes <input type="checkbox"/> No	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
*Eligible Disability:			
Migrant Status:			

B. Incident Description	
Date incident occurred:      /      /	<input type="checkbox"/> PHYSICAL RESTRAINT <input type="checkbox"/> SECLUSION:      Locked Room <span style="margin-left: 150px;"><input type="checkbox"/> Y    <input type="checkbox"/> N</span>
Time <b>restraint/seclusion</b> began (circle type):	Location of incident: <input type="checkbox"/> Classroom: Teacher _____ <input type="checkbox"/> Playground <input type="checkbox"/> Hall <input type="checkbox"/> Cafeteria <input type="checkbox"/> Other: _____
Time <b>restraint/seclusion</b> ended (circle type):	
What dangerous behavior(s) did the student exhibit that resulted in restraint/seclusion? (check all that apply) <input type="checkbox"/> Hitting <input type="checkbox"/> Biting <input type="checkbox"/> Running <input type="checkbox"/> Pushing <input type="checkbox"/> Choking <input type="checkbox"/> Spitting <input type="checkbox"/> Cutting <input type="checkbox"/> Using objects as weapons <input type="checkbox"/> Other _____	
Behavior(s) directed at <input type="checkbox"/> Staff <input type="checkbox"/> Peers <input type="checkbox"/> Self <input type="checkbox"/> Other: _____	
Behavior(s) the student exhibited prior to incident: <input type="checkbox"/> Yelling/calling out <input type="checkbox"/> Throwing objects <input type="checkbox"/> Out of seat/wandering <input type="checkbox"/> Cursing <input type="checkbox"/> Shutting down/refusing to complete task <input type="checkbox"/> Other _____	
Objectively describe the incident:	
Intervention(s)/effort(s) attempted to de-escalate student prior to or during physical restraint/seclusion (explain/describe):	
Type/method of restraint used (i.e. supine, standing)?	
Describe what occurred after student was restrained/secluded?	

<sup>1</sup> To be completed within 24 hours following the incident. A copy should be sent to the parent(s) within 1 school day of the Record being completed.

Did the incident result in any injuries? <input type="checkbox"/> No <input type="checkbox"/> Yes:	
Name of injured:	<input type="checkbox"/> Staff <input type="checkbox"/> Student <input type="checkbox"/> Other: _____
Name of injured:	<input type="checkbox"/> Staff <input type="checkbox"/> Student <input type="checkbox"/> Other: _____
Was medical treatment sought for the student as a result of the use of physical restraint: <input type="checkbox"/> No <input type="checkbox"/> Yes, by district <input type="checkbox"/> Yes, by parent(s) (if known to district)	

C. Staff administering the physical restraint/seclusion				
Staff: (Print Name)	Position:	Received training prior to restraint:	If yes, restraint Program:	Certified:
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

D. Staff observing the incident	
Staff: (Print Name)	Position:

E. Administrator Notification			
(A building administrator should be notified as soon as possible but no later than the end of the school day on which the incident occurred.)			
Name and position of administrator contacted:	Date:	Type of notification:	Staff member who contacted administrator:
	Time of contact:	<input type="checkbox"/> Verbal <input type="checkbox"/> Electronic <input type="checkbox"/> Written	

F. Parent Notification			
(Parent(s) should be verbally or electronically notified as soon as possible but no later than the end of the day on which the incident occurred, or written communication sent within 48 hours of the incident.)			
Name of parent(s)/ guardian(s) contacted:	Date:	Type of notification:	Staff member who contacted parent(s)/ guardian(s):
	Time of contact:	<input type="checkbox"/> Verbal <input type="checkbox"/> Electronic <input type="checkbox"/> Written	

Parent(s) received a copy of the Incident Record on \_\_\_\_\_, \_\_\_\_\_  
Date Parent Signature

**G. Debriefing Information**

(To be completed within 2 school days of the incident by all district personnel present before and/or during the incident.)

Date of debriefing meeting:	Time:	Location:
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Debriefing for **restraint/seclusion** (circle type):

Consideration of:

- What is the student's social/medical history?
- What are the results of any of the student's Functional Behavioral Assessment(s)?
- What is outlined in the student's Behavior Intervention Plan and was it implemented?
- What are the Special Factors listed in the student's Individualized Education Program (IEP)?
- What are the training needs of the staff relative to restraint/seclusion?
- What are the parent's concerns?
- How often has the student been restrained/secluded (frequency/duration)?

What actions need to be taken to prevent and reduce the need for restraint/seclusion?

District Personnel \_\_\_\_\_

Student \_\_\_\_\_

Parent \_\_\_\_\_

Printed name of those attending debriefing meeting	Signature of those attending debriefing meeting	Position

This report has been prepared by (Name / Position / Date):

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