

Department of Student Services

Physical Restraint/Seclusion Intervention Report

1. Student Name: _____		<input type="checkbox"/> Physical Restraint	<input type="checkbox"/> Seclusion
Race: _____	Gender: _____	School: _____	Grade: _____
Date of Intervention: _____		Time intervention began/ended: _____	
Location of intervention: <input type="checkbox"/> Classroom <input type="checkbox"/> Hall <input type="checkbox"/> Cafeteria <input type="checkbox"/> Playground <input type="checkbox"/> Other: _____			
2. Describe the antecedent behaviors that led to the intervention (who was the behavior directed at?):			
3. Describe the learning activity the student(s) was engaged in immediately preceding use of the intervention:			
4. Thorough description of efforts made to de-escalate and alternatives to the intervention that were attempted:			
5. How intervention ended (<i>check all that apply</i>):			
<input type="checkbox"/> Determination by staff member that student was no longer a risk to himself or others			
<input type="checkbox"/> Intervention by administrator(s) to facilitate de-escalation			
<input type="checkbox"/> Law enforcement personnel arrived			
<input type="checkbox"/> Staff sought medical assistance			
<input type="checkbox"/> Other (<i>describe</i>): _____			
6. Student's behavior during intervention:		7. Student's behavior after intervention:	
8. Was there any injury? <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>if yes, as per district policy, if injury occurred, complete Accident Report (A-W 121 for student, 2 part form Report by Injured Employee & Supervisor's Accident Investigation Report for staff).</i>)		9. Was there any damage? (Describe)	
<u>10. Staff Involved: Name/Position</u>		<u>Certification Current?</u>	
<u>(Staff who initiated intervention)</u>		<u>Previously Trained?</u>	
	<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
11. Parent Notification (within 24 hours of incident)			
Name of parent(s) contacted: _____			
Method of contact:			
<input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> In Person <input type="checkbox"/> Parent Notification Form mailed <input type="checkbox"/> Other _____			
Date and time of contact: _____ (am/pm)		Parent contact made by: _____	

This report has been prepared by

(Name)

(Position)

Copies to: IEP case manager, building administrator, Coop Office