

Lisbon School Department INCIDENT REPORT PHYSICAL RESTRAINT or SECLUSION OF A STUDENT	JKAA-F
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NAME OF SCHOOL/PROGRAM:	DATE OF REPORT:
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NAME OF PERSON COMPLETING THE REPORT:

STUDENT INVOLVED

STUDENT NAME:	Age:	Gender:	Grade:
STUDENT HAS (Check all that apply)			
<input type="checkbox"/> IEP	<input type="checkbox"/> IHP		
<input type="checkbox"/> 504 Plan	<input type="checkbox"/> Other Plan (Identify)		
<input type="checkbox"/> Behavior Plan	<input type="checkbox"/> None of these plans		

DESCRIPTION OF INCIDENT:	
DATE OF INCIDENT:	
BEGINNING TIME OF INCIDENT:	ENDING TIME OF INCIDENT:
TOTAL INCIDENT TIME:	

LOCATION OF INCIDENT (BE SPECIFIC):			
<input type="checkbox"/> Classroom	<input type="checkbox"/> Bathroom	<input type="checkbox"/> Hallway	<input type="checkbox"/> Specials Room _____
<input type="checkbox"/> Gym	<input type="checkbox"/> Vehicle	<input type="checkbox"/> Lobby	<input type="checkbox"/> Community _____
<input type="checkbox"/> Cafeteria	<input type="checkbox"/> Playground	<input type="checkbox"/> Front of School	<input type="checkbox"/> Other _____
<input type="checkbox"/> Library	<input type="checkbox"/> Office		

ANTECEDENTS (Describe Detail; Prior to Behavior)	
<input type="checkbox"/> Loud Noise(s): _____ <input type="checkbox"/> Delivering Academic Instruction: _____ <input type="checkbox"/> Limit Setting/Redirection: _____ <input type="checkbox"/> Space Intrusion: _____ <input type="checkbox"/> Difficult Task: _____ <input type="checkbox"/> Transition: _____ <input type="checkbox"/> Novel Activity/Person/Item: _____ <input type="checkbox"/> Schedule Change: _____	<input type="checkbox"/> Peer Interaction(s): _____ <input type="checkbox"/> Teacher Directives: _____ <input type="checkbox"/> Activity Characteristic(s): _____ <input type="checkbox"/> Crowding/Proximity: _____ <input type="checkbox"/> Unclear/Undetected: _____ <input type="checkbox"/> Waiting: _____ <input type="checkbox"/> Other: _____

BEHAVIORAL ANTECEDENTS (Prior to Behavior)	
<input type="checkbox"/> Body Movement(s): _____ <input type="checkbox"/> Facial Expression(s): _____ <input type="checkbox"/> Vocal/Verbal: _____ <input type="checkbox"/> Noncompliance: _____	<input type="checkbox"/> Confused/disoriented: _____ <input type="checkbox"/> Ambulation/Pacing: _____ <input type="checkbox"/> Other: _____

LEAST RESTRICTIVE INTERVENTIONS- check all used and be specific	
<input type="checkbox"/> Differential Reinforcement: _____ <input type="checkbox"/> HELP (Safety-Care): _____ <input type="checkbox"/> PROMPT (Safety-Care): _____ <input type="checkbox"/> WAIT (Safety-Care): _____ <input type="checkbox"/> Incident Minimization Technique: _____ <input type="checkbox"/> Verbal Directive(s): _____ <input type="checkbox"/> Verbal De-escalation: _____	<input type="checkbox"/> Physical Prompt: _____ <input type="checkbox"/> Low stimulus environment offered: _____ <input type="checkbox"/> Relocation: _____ <input type="checkbox"/> Support Offered: _____ <input type="checkbox"/> Retreat/Re-Approach: _____ <input type="checkbox"/> Increased Monitoring: _____ <input type="checkbox"/> Other: _____

RESPONSE TO INTERVENTIONS – check all that apply
<input type="checkbox"/> Independent Calm: _____ <input type="checkbox"/> Re-entered Previous Situation: _____ <input type="checkbox"/> Activity Participation: _____ <input type="checkbox"/> De-Brief/Processing: _____ <input type="checkbox"/> Continued Behavior w/out Escalation: _____ <input type="checkbox"/> Increased Escalation: _____ <input type="checkbox"/> Other: _____

DESCRIPTION OF THE INCIDENT: including the resolution and process of return of student to program if appropriate. (if another student is involved, use only their initials)

IF NO LESS RESTRICTIVE INTERVENTIONS WERE TRIED PRIOR TO THE USE OF PHYSICAL RESTRAINT/SECLUSION – EXPLAIN WHY

STUDENT BEHAVIOR JUSTIFYING USE of PHYSICAL RESTRAINT/SECLUSION

Imminent risk of serious harm No other practical way to prevent serious harm Risk of intervening > not intervening

DESCRIBE:

DESCRIPTION OF RESTRAINT OR SECLUSION; STAFF INVOLVED
REMEMBER: 2 adults for restraints & 1 adult for seclusion is required (minimum)

Detailed description of the physical restraint/seclusion used:

Staff person involved	Their role in the use of physical restraint/seclusion	Certification, if any, in an approved training program

DID RESTRAINT OR SECLUSION LAST MORE THAN 10 MINUTES:

Yes

If yes, time of notification to the Administrator & approval to continue restraint or seclusion- (every 10 minutes required):

No

BEGINNING TIME OF RESTRAINT/SECLUSION:	ENDING TIME OF RESTRAINT/SECLUSION:
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BODILY INJURY OF STUDENT OR STAFF		
Did the student or staff sustain bodily injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, name of person(s) sustaining injury (if another student, use initials):		
Describe injury(ies) sustained:		
Date and time of nurse or response personnel notification and treatment administered (if any):		
Did student sustain SERIOUS bodily injury or death:		
<input type="checkbox"/> Yes If yes, date and time of notification to the Superintendent & DOE:		
<input type="checkbox"/> No		

NOTIFICATION AND DEBRIEFING

Parent Notified: (same day)	Date:	Time:	Method:	Personnel Involved:
Administrator Notified: (same day)	Date:	Time:	Method:	Personnel Involved:
Written Report to Administrator: (w/in 2 school days)	Date:	Time:	Personnel Involved:	
Staff Debriefing: (w/in 2 school days) (include what went well)	Date:	Time:	Personnel Involved:	
Student Debriefing: (w/in 2 school days)	Date:	Time:	Personnel Involved:	
Parent Written Notification: (w/in 7 calendar days)	Date:	Time:	Personnel Involved:	
Written Plan Shared w/staff: (include what would be done differently)	Date:	Time:	Personnel Involved:	
Has student been involved in 2 or more prior incidents during the current school year?				
<input type="checkbox"/> Yes				
If yes, Date and time of required team meeting (w/in 10 school days):				
<input type="checkbox"/> No				
If no, number of prior incidents during the current school year:				
Signature of Person(s) Completing Report:			Date:	
Signature of Director of Student Services:			Date:	
Signature of Superintendent of Schools:			Date:	

Mailed By: Office of Student Services
Cc: Cum File, Pinnacle, Building Level Administrator
 October 16, 2013

Reviewed: November 9, 2015
Reviewed: November 12, 2019