FAIRFIELD CITY SCHOOL DISTRICT

RESTRAINT AND/OR SECLUSION INCIDENT FORM

*Every section must be completed in its entirety.

Student Name: _____ Date of Incident: _____

Time of Day: _____ a.m./p.m. Gender: Female Male Grade: _____

School: _____

Trigger Behavior:

_____ danger to self _____ danger to others

DURING THE INTERVENTION

Time Transport BEGAN ____am/pm Time Transport ENDED ____am/pm Total Minutes ____

Time Restraint BEGAN ____am/pm Time Restraint ENDED ____am/pm Total Minutes____

Seclusion implemented by: _____

Restraints: (Please circle all that apply)

Children's Control Position Team Control Position N/A

Interim Control Position Transport Position

PRIOR TO THE INTERVENTION

Describe the de-escalation strategies used prior to the intervention:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please check all alternative interventions attempted by staff:

___ Clarify rules and expected behavior
___ Change seating or activity
___ Restate directions
___ Change schedule
___ Praise
___ Positive reinforcers
___ Negative reinforcers
___ Caring gestures
___ Prompting
___ Verbal reprimand
___ Reward program
___ Reduction of privileges
___ Relaxation techniques
___ Written contract with student
___ Break times
___ Time out
___ Directive statements
___ Planned ignoring

Describe the trigger event behaviors displayed: (specify behaviors that demonstrate harm to self or others)

Describe what you specifically told the student (during the intervention) about his/her behavior that would allow you to "let go" of him/her:

AFTER THE INTERVENTION: Therapeutic Rapport: (description of student's physical/emotional condition, appearance and behavior upon release from the restraint)

Describe student's general physical/emotional status/behavior upon release:

_____

_____

_____

_____

Was student injured during intervention? Yes ____ No ____
Did student complain of injury? Yes ____ No ____

Staff person's **name and signature** that completed injury check:

Name: _____ Signature _____

Nurse's notes: (if student injury or complaint)

_____

_____

_____

_____

_____

Nurse's Name:_____ Nurse's Signature:_____

_____

STUDENT MUST BE OFFERED ALL OF THE FOLLOWING:
Food _____ Fluids _____ Toileting _____ Other:_____
(please check the ones which the student actually needed)

Reflect with student and summarize student's point of view of the events: (use additional sheets if necessary)

_____

_____

_____

_____

_____

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_____

_____

Discuss alternative behavior(s) – What specific activities could work for the student to help de-escalate him/her in a similar situation?

_____

_____

_____

_____

_____

Notes regarding initial contact with family:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Name and signature of staff making notification call to family/guardian:

Name:_____ Signature:_____

REQUIRED NOTIFICATION

Individuals notified:

Name	Code	Date	Time	Contacted By
1._____	_____	_____	_____	_____
2._____	_____	_____	_____	_____
3._____	_____	_____	_____	_____
4._____	_____	_____	_____	_____
5._____	_____	_____	_____	_____

6. Building Principal and Special Services Director must receive a copy of each report when a restraint is conducted within one day of occurrence.

Codes:
1. Parents/Guardian
2. Nurse (if at 30 minute restraint)
3. Building Principal
4. Guardian Ad Litem
5. Case Worker
6. Special Services Director