Seclusion or Restraint Report

Student Name:	School:		Grade:
Location:	Total minutes seclusion:	Total minutes restraint:	Date of incident:

Staff persons initiating, involved in, or present during seclusion/restraint (include name and title):

Describe the behavior that led to seclusion/restraint, including time, location, activity, other contributing factors:

Procedures used to attempt to de-escalate the student prior to using seclusion/restraint:

Student behavior during seclusion/restraint: (Minimum report every 5 minutes.)

Time	Student Behavior

Was seclusion used? ☐ Yes ☐ No Was restraint used? ☐ Yes ☐ No

If yes to retraint, which type? ☐ Child Control ☐ Team Control ☐ Transport

Was there any injury or damage? ☐ Yes ☐ No

If yes, briefly describe and complete a district accident report form:

Behaviors displayed demonstrating the student's ability to return to educational environment from seclusion/restraint:

Required follow-up after the seclusion/restraint (check one or more):

☐ Reconvene IEP ☐ Conduct FBA ☐ Develop BIP ☐ Review/Revise BIP ☐ Convene SST

☐ Team Debriefing ☐ Parent/Guardian Conference ☐ Other- please specify:

Administration Contacted:	Parent/Guardian Contacted:
Date: _____ Time: _____	Date: _____ Time: _____
Method: _____ Initials: _____	Method: _____ Initials: _____

Person Completing Report:	Date:

CC: Building Administration , Student Services Coor., Student Services Director, Professional Development Dir.