Douglas County School District
Learn Today, Lead Tomorrow
620 Wilcox Street
Castle Rock, Colorado 80104

STUDENT RESTRAINT INCIDENT REPORT FORM

To be completed on the day of the restraint

- Send to: studentrestraintreports@dcsdk12.org
- Copies to Family and Building Administrator

Make sure all sections are filled in completely

STUDENT INFORMATION

Student Name: Last, First	**School:** **Grade:**
Date of Incident:	**Location of Incident:**
Race: ☐ White ☐ African American ☐ Hispanic ☐ Asian ☐ American Indian ☐ Other:	**Denote Gender in IC:** ☐ Male ☐ Female
Denote Programming: ☐ Regular Education ☐ Not on a 504 ☐ Yes on a 504 ☐ Special Education? Special Education qualification(s) on IEP? If ASD is the classification ☐ Primary or ☐ Secondary	**Denote Special Education Programming:** ☐ Moderate Needs ☐ Affective Needs Center-Based ☐ SSN Center-Based ☐ ASD Center-Based
Denote Plan: Does this student have a Behavior Intervention Plan (BIP) in their IEP? ☐ Yes ☐ No Date of last FBA? Date of last BIP?	**Denote Time:** Time Restraint Began: _____ Time Restraint Ended: _____ Did the Restraint Last 1 Min. or less: ☐ Yes ☐ No

Denote the Type of Injury to the student (only list injuries that happened during the restraint)	**What type of medical attention was needed- please describe:**

☐ Scratch ☐ Bruise ☐ Pinch ☐ Cut ☐ No Injury occurred ☐ Other:	

Denote the Type of Restraint Used:

☐ 2 person Medium Seated ☐ 2 person High Seated ☐ 2 person Medium Standing ☐ 2 person High Standing	☐ 1 person Children's Control Med. Seated ☐ 1 person Children's Control High Seated ☐ 1 person Children's Control Med. Standing ☐ 1 person Children's Control High Standing ☐ Non-CPI Hold (Explain in Event Details)

STAFF INFORMATION

Staff Performing Restraint:

Name and Title

Witnesses to the Restraint:

Name and Title

Denote the Type of Staff Injury and to whom: (only list injuries that happened during the restraint)	**What type of medical attention was needed- please describe:**
☐ Scratch to ☐ Bruise to ☐ Pinch to ☐ Bite to ☐ Cut to ☐ No injury occurred ☐ Other _____	

EVENT DETAILS

Brief Chronological Description of Event (include behavior, statements made, actions taken- objective factual information/ bullet points or limited narrative. If an injury occurred during the restraint describe this also.) (If non-CPI restraint was used explain the reasoning.):
Precipitating Factors/ Antecedents: (describe what happened before the behavior occurred- including known antecedents or other challenges that may have contributed to the escalation):

Possible Function(s): What was the student trying to <u>Obtain</u> or <u>Avoid</u> with their behavior?	☐ Escape/Avoid Task or Environment ☐ Protection/Safety ☐ Attention ☐ Affiliation / Affirmation ☐ Sensory ☐ Tangible
Lagging Skill(s): Which of the following Lagging Skill cluster(s) impacted the situation?	☐ Language and communication ☐ Attention and working memory ☐ Emotion & self- regulation ☐ Cognitive Flexibility ☐ Social Thinking
Efforts/ Alternatives made to de-escalate the situation prior to the use of restraint:	☐ Verbal or Non-Verbal Cues ☐ Offered Self-Control Strategy ☐ Verbal de-escalation ☐ Offered a break ☐ Room Clear ☐ Other Interventions: Important Details if needed:
Resolution:	☐ Student calm/ reintegrated into the instructional setting ☐ Student calm/ additional time provided for de-escalation outside of the instructional setting ☐ Additional support requested (i.e., medical/ mental health/ parent/ police ☐ Other(s):

NEXT STEPS

Parent Guardian Notification occurred by:	Name: Title: Date: Time:
Team Member to initiate review meeting (COPING Model): Address' whether appropriate procedures were followed and alternative strategies were used, and make recommendations for adjustment of procedures, if appropriate) for future intervention:	Name: Title:

_____ _____

Person/ Title Submitting Report Signature (typed name denotes signature)