

Students

Exhibit – Documented Physical Restraint

Student's Name: _____ Date: _____
Start Time: _____ End Time: _____

Description of incident that led to physical restraint being used:

Interventions used prior to initiating physical restraint: (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Allowing student to escape task | <input type="checkbox"/> Call parents regarding behavior |
| <input type="checkbox"/> Environment/activity modifications | <input type="checkbox"/> Modeling |
| <input type="checkbox"/> Peer mediation | <input type="checkbox"/> Planned ignoring |
| <input type="checkbox"/> Prompting | <input type="checkbox"/> Verbal reprimand |
| <input type="checkbox"/> Proximity control | <input type="checkbox"/> Verbal re-direction |
| <input type="checkbox"/> Shaping | <input type="checkbox"/> Teaching alternative behavior |
| <input type="checkbox"/> Detention after-school | <input type="checkbox"/> Response cost strategy (points) |
| <input type="checkbox"/> Punishment writing | <input type="checkbox"/> Physical re-direction |
| <input type="checkbox"/> Time-out | |

Other interventions: _____

Type of physical restraint used: _____

Description of the student's behavior while in restraint:

What plan will be initiated to remediate student's behavior that lead to physical restraint:

Staff members involved/witnessing physical restraint:

Did student suffer any injury: No Yes - Describe injury: _____
Did any staff suffer injury: No Yes - Describe injury: _____
Was there damage to property: No Yes - Describe damage: _____

If the physical restraint exceeds **15 minutes**, notify certified staff, knowledgeable/trained in the use of physical restraint and complete page 2 of this form.

Staff member completing this form: _____
Principal's signature: _____ Date: _____ Time: _____

**To be completed by Certified Staff knowledgeable/trained
in Physical Restraint**

Evaluation of physical restraint currently being used:

Is the restraint still appropriate given that it has exceeded 15 minutes: Yes No

Reason for continued use or discontinued use: _____

Does the student need medication: Yes No

Does the student need nourishment: Yes No

Does the student require an alternate strategy:

_____ School social work services _____ School psychological services
_____ Police Intervention _____ Ambulance

Certified Staff Member signature: _____

Date: _____ Time: _____

Developed: September 2002

