

FALL RIVER PUBLIC SCHOOLS *"The Scholarship City"*

417 Rock Street, Fall River, MA 02720

Matthew H. Malone, Ph.D.
Superintendent

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Executive Director of Special Education
and Student Services

File: JKAA-E

PHYSICAL RESTRAINT FORM

Name of Student: _____ SASID: _____ Gender: M _____ F _____

Date: _____ School: _____

Time Restraint Began: _____ Time Restraint Ended: _____ Subject/Period: _____

Name and Job Title of person(s) performing restraint: _____

Name and Job Title of Witnesses: _____

Name of administrator who was verbally notified following restraint: _____

Parent notified (date, time, and manner of notification): _____

Student has an IEP: Yes _____ No _____ Student has a 504 plan: Yes _____ No _____

Description of activity which took place prior to restraint and behavior which prompted restraint, including justification for initiating restraint: _____

What efforts were made to de-escalate the situation and what alternatives to restraint were attempted?

Describe the type of restraint administered, why it was chosen and how the student acted during the restraint: _____

Describe how the restraint ended: _____

Were there any injuries to student or staff? _____

If an injury took place, please describe the nature of the injury and any care provided. (Attach a copy of accident report where appropriate): _____

To be completed for extended restraints only (those in excess of 20 minutes.)

- 1) What alternatives were attempted, and what were the outcomes of those efforts.
- 2) Describe the justification for administering extended restraint:

Name of administrator who approved restraint beyond 20 minutes: _____

Explain the outcome or resolution of this incident and additional actions the school is taking:

Opportunities for student's parents to discuss restraint

Name and title of person preparing this report

Date Sent: _____

CC: Parent/Guardian, Principal, Special Needs Supervisor