**Model Restraint and Seclusion Debriefing Form**

|  |  |
| --- | --- |
| Student Name: |  |
| Date of Incident: |  | Duration of Incident: |  |
|  |  |  |  |  |  |
| [ ]  | Restraint | [ ]  | Seclusion | Date of Debriefing: |  |
| Is there a behavior goal or behavior plan as part of an Individualized Education Program, Functional Behavioral Assessment, Behavior Intervention Plan or 504 plan? |
| [ ]  | Yes | [ ]  | No | If yes, how was it followed? |
|  |
| Provide a brief description of the circumstances (antecedents) leading up to this incident. |
|  |
| What less restrictive interventions were tried to deescalate the situation? |
|  |
| Give a summary of the incident. |
|  |
|  |
| Was the student reintroduced back into the classroom? If so, what worked to calm the student? If not, what happened with the student? |
|  |
|  |
| Based on observations before, during and after student interventions, should changes to adult response to student or student planning documents be made? |
|  |
| Do these changes impact any of the following? Note: If this is the third instance of restraint or seclusion in this school year, a meeting must be held to determine if a Functional Behavioral Assessment must be created or reviewed. |
| [ ]  | Individualized Education Program | [ ]  | Functional Behavioral Assessment  |
| [ ]  | Behavior Intervention Plan  | [ ]  | 504 Plan |
|  If yes, name of person responsible for notifying the team: |  |
| [ ]  | Individualized Education Program | Date: |  |[ ]  N/A |
| [ ]  | Behavior Intervention Plan  | Date: |  |[ ]  N/A |
| [ ]  | Functional Behavioral Assessment | Date: |  | [ ]  | N/A |
|  [ ]  | 504 Plan | Date: |  |[ ]  N/A |

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| --- |
| Additional comments (if any): |
|  |
|  |
| The parent/guardian must be contacted on the day of the incident. Was the parent/guardian contacted on the day of the incident? |
| [ ]  | Yes  | [ ]  | No | If no, why not? |
|  |
| Were there any preexisting medical conditions to be considered before restraint/seclusion? |
| [ ]  | Yes | [ ]  | No | If yes, list: |  |
| If complaint of injury by student, describe: |
|  |

Was a medical evaluation provided to student following restraint/seclusion?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  | Yes | [ ]  | No | If yes, attach a copy of the medical evaluation |

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Position in restraint or seclusion or witness  | Signature | Has the staff completed annual crisis intervention training? |
|  |  |  | [ ]  | Y | [ ]  | N |
|  |  |  | [ ]  | Y | [ ]  | N |
|  |  |  | [ ]  | Y | [ ]  | N |
|  |  |  | [ ]  | Y | [ ]  | N |
|  |  |  | [ ]  | Y | [ ]  | N |
|  |  |  | [ ]  | Y | [ ]  | N |

**Notes for district personalization**

Include best practices following crisis intervention planning that may help the student process the event in the best way (seeing a counselor, talking to a teacher, writing in a journal, processing with sensory items).

Include process for requesting additional resources for both staff and families.

If your school/district has any additional training and certification requirements, please include those elements on the form.