Connecticut State Department of Education

Incident Report of Physical Restraint

FORM 1  5144.1
Revised 8/19/2019

Note: Any use of physical restraint is to be documented in the child’s educational record and, if appropriate, in the child’s school health record. Recording of the information contained in the Connecticut State Department of Education Incident Report of Physical Restraint is required and should be completed as soon after the incident as possible or within 24 hours of the incident.

Physical Restraint means any mechanical or personal restriction that immobilizes or reduces the free movement of a child’s arms, legs or head. Including but not limited to, carrying or forcibly moving a person from one location to another.

Physical restraint does not include: (1) briefly holding a child in order to calm or comfort the child; (2) restraint involving the minimum contact necessary to safely escort a child from one area to another; (3) medication devices, including supports prescribed by a health care provider to achieve proper body position or balance; (4) helmets or other protective gear used to protect a child from injuries due to a fall; or (5) helmets, mitts and similar devices used to prevent self-injury when the device is part of a documented treatment plan or IEP and is the least restrictive means available to prevent self-injury.

District Information

School District: _______________ Address: __________________ Phone: __________

School: _____________________ Address: __________________ Phone: __________

Date of Restraint: _____________ Date of Report: _____________

Person preparing the report: _______________

Time restraint initiated _______ Time restraint ended _______ Total time of restraint ______*

*If the total length of the restraint exceeds 15 minutes, attach the documentation of the required Administrator’s (or designee) determination of the need for continuation of the restraint to prevent immediate or imminent injury to the student or to others.

Student Information

Student’s Name: __________________ SASID #: _______________ Date of Birth: _______

Age: ______ Gender (M /F): ______ Grade: _____ Race: _____ Disability: __________

____ The student is a general education student.

____ The student currently receives special education services.

____ The student is being evaluated or considered for eligibility for special education services.

Staff Information

Name of staff administering restraint: __________________________ Title________________

Name of staff monitoring/witnessing restraint: ____________________ Title________________

Student activity/behavior precipitating use of restraint

Describe the location and activity in which the student was engaged just prior to the restraint:

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________
Describe the risk of immediate or imminent injury to the student restrained or to others that required the use of restraint:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**Staff activity/response**

Describe other steps, including de-escalation strategies implemented to prevent the emergency, which necessitated the use of restraint:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**Protective Hold Information** (please circle protective hold technique used) # of persons required________

<table>
<thead>
<tr>
<th>Non-Floor Protective Hold</th>
<th>Floor Protective Hold</th>
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<tbody>
<tr>
<td>Limited Security Hold</td>
<td>One-Person Floor Take Down</td>
</tr>
<tr>
<td>Full Security Hold</td>
<td>Two Person Floor Take Down</td>
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<tr>
<td>Standing Wedge Hold</td>
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<tr>
<td>Standing Wall Hold</td>
<td>Three Person Floor Hold</td>
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Forced Escort:
- Yes
- No

Name other PMT hold used:

Start Hold________:_______ am/pm  Start Floor Prot. Hold:__:_ am/pm
End Hold________:_______ am/pm  End Floor Prot. Hold:__:_ am/pm
Total Minutes:_____________  Total Minutes:_____________

On what date, within the last 12 months, did you inquire if the student has any known medical or psychological conditions that would be directly and adversely impacted by the use of seclusion or restrain as a behavior intervention? ______________________

Did the student demonstrate physical distress during the restraint? _____ Yes   _____ No
Indicate times student was monitored for physical distress and if any signs of physical distress were noted:  __________________________________________________________________________

**Nursing Report:**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Observed student’s physical management: _______ Yes _______ No
Performed initial assessment at:_______am/pm
Performed follow up assessment at:_______am/pm
Accident/Incident Report completed: _____ Yes _____ No
Documentation in Cumulative Health Record (CHR) Date: ____/____/____
Date of Assessment: _____/____/____  Signature: _________________________________

Describe the disposition of the student following the restraint:
__________________________________________________________________________________

Was the student injured during the emergency use of restraint?  _____ Yes  _____ No
If “yes,” complete and attach a Report of Injury.

On what date did you put a copy of this form in the student’s cumulative file?
____________________________________________________

Parent/Guardian Notification
Was parent/guardian notified within 24 hours of the incident?
_____ Yes (indicate manner) __________________________________________________________
_____ No

Was a copy of the Incident Report sent to parent/guardian within two business days?
_____ Yes  _____ No

Is a* PPT required to review/revise the IEP or discuss additional evaluation or the
development/revision of a FBA and or BIP?  _____ Yes  _____ No

Is a PPT recommended to modify the IEP?  _____ Yes  _____ No  If “yes,” indicate date _____

Is a *meeting required for this general education student?  _____ Yes  No______
If “yes,” indicate date _____

*A PPT or a meeting is required if this incident marks the 4th incident of restraint or seclusion within a twenty
school day period
To be completed in the event that a student is restrained or secluded for a period exceeding 15 minutes.

Public Act 15-141 requires that an administrator, as defined in section 10-144e of the general statutes, or such administrator's designee, a school health or mental health personnel, or a board certified behavioral analyst, who has received training in the use of physical restraint and seclusion, shall determine whether continued physical restraint or seclusion is necessary to prevent immediate or imminent injury to the student or to others. Upon a determination that such continued physical restraint or seclusion is necessary, such individual shall make a new determination every thirty minutes thereafter regarding whether such physical restraint or seclusion is necessary to prevent immediate or imminent injury to the student or to others.

Time restraint or seclusion was initiated: _____________ a.m. /p.m.
Time restraint or seclusion was terminated: _____________ a.m. /p.m.

15 minute determination of the necessity of continued restraint or seclusion:__________a.m. /p.m.

Signature of qualified* administrator, designee, school health or mental health professional

30 minute determination of the necessity of continued restraint or seclusion:__________a.m. /p.m.

Signature of qualified* administrator, designee, school health or mental health professional

30 minute determination of the necessity of continued restraint or seclusion:__________a.m. /p.m.

Signature of qualified* administrator, designee, school health or mental health professional

30 minute determination of the necessity of continued restraint or seclusion:__________a.m./p.m.

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Time restraint or seclusion was initiated: _____________ a.m. /p.m.
Time restraint or seclusion was terminated: _____________ a.m. /p.m.

15 minute determination of the necessity of continued restraint or seclusion:__________a.m. /p.m.

Signature of qualified* administrator, designee, school health or mental health professional

*qualified is defined as having received required training in the use of physical restraint and seclusion