



**TENNESSEE DEPARTMENT OF EDUCATION
REPORT OF ISOLATION / RESTRAINT**

**This form must be completed by school personnel who restrain or isolate a student with a disability.
T.C.A. §49-10-1304.**

STUDENT INFORMATION

Name _____ Age _____ Disability _____

School _____ Grade Level _____ Date _____

Location in School Facility _____
Room Number or Area Where Isolation/Restraint Administered

Time Isolation/Restraint Began _____ Time Isolation/Restraint Ended _____
Circle One Circle One

PERSONNEL ADMINISTERING ISOLATION/RESTRAINT AND COMPLETING THIS REPORT

Name _____ Name _____

Signature _____ Signature _____

Job Title _____ Job Title _____

Certified for Behavior Intervention Y N
Circle One

Certified for Behavior Intervention Y N
Circle One

OTHER PERSONNEL WHO OBSERVED/WITNESSED THE ISOLATION/RESTRAINT

Name _____ Name _____

Job Title _____ Job Title _____

PRINCIPAL NOTIFICATION ON DATE OF ISOLATION/RESTRAINT

Name of Principal (or designee) Notified _____ Time of Notification _____

PARENT NOTIFICATION ON DATE OF ISOLATION/RESTRAINT

Name of Parent _____ Time of Notification _____

Method of Notification _____ Notified By _____
In Person/Telephone/E-Mail/Fax Name and Job Title of Person Notifying Parent

