

SCHOOL INCIDENT REPORT

ARCHDIOCESE OF WASHINGTON Catholic Schools

REPORT DATE: _____

PERSON SUBMITTING THIS REPORT:

Name: _____ Title: _____

Direct Daytime Phone: _____ Email: _____

SCHOOL INFORMATION

School: _____ Principal: _____

Address: _____

School Phone (main): _____ Direct: _____ Cell: _____

Incident Date: _____ Incident Time: _____ Incident Location: _____

INCIDENT DESCRIPTION:

Please be specific. Include a detailed timeline of events leading up to and during the incident; list who was involved; and what steps were taken in response to the incident. Please include any disciplinary actions taken and contact made with parents. If more space is required, please attach additional page(s).

Please indicate the appropriate internal school contacts who have been notified of this incident:

- Pastor Name: _____ Date: _____ Time: _____
- Assistant Principal Name: _____ Date: _____ Time: _____
- School Counselor Name: _____ Date: _____ Time: _____
- School Nurse Name: _____ Date: _____ Time: _____
- School Admin. Staff Name: _____ Date: _____ Time: _____
- Other _____ Name: _____ Date: _____ Time: _____

Please indicate the person within the Catholic Schools Office who has been notified:

Catholic Schools Office Name: _____ Date: _____ Time: _____

Based on the nature of the incident, please indicate that the appropriate offices of the Archdiocese have been notified:

<input type="checkbox"/> Office of Child Protection	Name: _____	Date: _____	Time: _____
<input type="checkbox"/> Communications	Name: _____	Date: _____	Time: _____
<input type="checkbox"/> Chancery /Legal	Name: _____	Date: _____	Time: _____
<input type="checkbox"/> Human Resources	Name: _____	Date: _____	Time: _____
<input type="checkbox"/> Facilities Management	Name: _____	Date: _____	Time: _____
<input type="checkbox"/> Catholic Mutual	Name: _____	Date: _____	Time: _____
<input type="checkbox"/> Other _____	Name: _____	Date: _____	Time: _____

If applicable, please indicate the civil authorities contacted: (Police, Ambulance, Fire, Child Protective Services)

Date: _____ Time: _____ Person Who Made Initial Contact: _____

Name of Agency Contacted: _____

Name of Officer: _____ Phone Number: _____

Was anyone transported to the Hospital? NO YES Hospital Name: _____

If yes, please provide name and contact info of injured party and nature of injury/illness: _____

Witnesses - Student, Visitor and Staff Information: *Please provide the following information for all student(s), visitors or staff involved or witness to the incident.*

1	Name: _____ Grade: _____ Age: _____ Parent/Guardian Name: _____ Phone Number: _____
2	Name: _____ Grade: _____ Age: _____ Parent/Guardian Name: _____ Phone Number: _____
3	Name: _____ Grade: _____ Age: _____ Parent/Guardian Name: _____ Phone Number: _____
4	Name: _____ Position: _____ Home Phone: _____ Alternate Phone: _____
5	Name: _____ Position: _____ Home Phone: _____ Alternate Phone: _____

Completed By: _____ Position: _____

Signature: _____ Date: _____