DISTRICT OFFICE
930 Westacre Road
West Sacramento, CA 95691

TEL (916) 375-7600
FAX (916) 375-7619
www.wusd.k12.ca.us

Washington Unified School District
Suspected Bullying Report – CONFIDENTIAL

Complete this form if you have credible information regarding a bullying incident.
Please forward to the site administrator *immediately.*

☐ **Person reporting alleged incident:** **OR** ☐ **Anonymous reporter**

Name/Title: _____

Phone: _____ Date: _____

Date of Incident(s):_____ School: _____

Name of Student Targeted: _____ Grade:_____

Name of Student Aggressor(s):_____Grade:_____

_____Grade:_____

Place an X next to the statement(s) that best describes what happened (choose all that apply):

☐ **Hitting**
☐ **Shoving**
☐ **Kicking**
☐ **Name-Calling**
☐ **Taking Property**
☐ **Destroying Property**
☐**Spreading Rumors**
☐**Internet Posting**
☐**Electronic Messaging**
☐**Slam Book**
☐**Exclusion**
☐**Social Cruelty (LIST):**

Other Physical Act (LIST):

_____ _____

Where did this incident take place?

☐**Bus Stop**
☐**Bus**
☐**Playground/Athletic Field**
☐**Other (LIST):** _____
☐**Cafeteria**
☐**Classroom**
☐**Locker Room**
☐**On the way to/from school**

When did this incident take place?

Date/time:_____
Date/time:_____
Date/time:_____

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Briefly describe sequentially what occurred (use additional paper as needed):

Person completing form, if not anonymous:

Name/Title:_____

Phone: _____

Signature: _____

Date: _____

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Suspected Bullying Report – CONFIDENTIAL
This Page To Be Completed by Administrator

Administrator Conducting Suspected Bullying Investigation:

Name: _____ **Title:** _____

Parties interviewed: ☐ **Aggressor** ☐ **Target** ☐ **Witnesses/Bystanders**

Summary of Investigation (use additional paper as needed):

_____

_____

_____

_____

_____

Investigation outcome: Did this situation meet the criteria as a suspected bullying incident:

☐ **Yes** ☐ **No** **If bullying did not occur, process is complete at this time.**

If bullying behavior occurred, develop a Student Bully Intervention Plan for the student who acted aggressively and for the targeted student.

Student Bully Intervention Plan completed for Aggressor ☐ **Yes** ☐ **No** **Date:**_____

Student Bully Intervention Plan completed for Target ☐ **Yes** ☐ **No** **Date:**_____

Contact the parent(s)/guardian(s) of the student(s) who are targeted and who did the bully behavior for this Incident:

Parent's/Guardian's Name:_____ **Date:**_____
Parent's/Guardian's Name:_____ **Date:**_____

Immediate Action Taken (involving Aggressor and Target):

Aggressor:	**Target:**
☐ **Referred to Principal- Date:**_____	☐ **Referred to Principal - Date:**_____
☐ **Parents/guardians contacted- Date:**_____	☐ **Parents/guardians contacted- Date:**_____
☐ **Other:**_____	☐ **Other:**_____

Administrator/Designee Signature:_____ **Date:** _____

Administrator: Please send copy of 1) Suspected Bullying Report form 2) Student Bully Intervention Plan to Director of Student and Family Support Services

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Washington Unified School District
Student Bully Intervention Plan

Complete this form with either the aggressor or the target involved in the bullying incident.

Date of Incident(s): _____
School:_____

Name of Student: _____ ☐ Target ☐ Aggressor

In order to be safe and keep others safe at school, you will:

1. _____
2. _____

In order to support your safety or the safety of others, the school will:

1. _____
2. _____

To support your safety and the safety of others, your family will:

1. _____
2. _____

If you feel you need more support, the school can recommend additional resources such as:

1. _____
2. _____

Student Signature: _____ Date:_____

Parent Signature: _____ Date:_____

Staff Signature: _____ Date:_____

Please indicate the staff person who will follow up with the student to see if the plan is working and if the student feels safe at school.

Name:_____ Date of follow-up:_____