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: ____________

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

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

Where did this incident take place?

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

When did this incident take place?

Date/time: __________________________

Date/time: __________________________

Date/time: __________________________
Briefly describe sequentially what occurred (use additional paper as needed):

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

Person completing form, if not anonymous:

Name/Title: ________________________________

Phone: ________________________________

Signature: ________________________________

Date: ________________________________
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: □ Referred to Principal – Date: ______
□ Parents/guardians contacted – Date: ______
□ Other: ______________________________ Date: __________________

Target: □ Referred to Principal – Date: ______
□ Parents/guardians contacted – Date: ______
□ Other: ______________________________ Date: __________________

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
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: ______________________________