



A. FACILITY INFORMATION:

Name of Legal Entity: _____

Address of Legal Entity: _____

Name of Facility (if not same as legal entity): _____

Address of Facility (if not same as legal entity): _____

Certificate of Compliance #: _____ County: _____

Type of Facility (check all applicable for this facility):
 Residential Secure Care Secure Detention
 Transitional Living Outdoor Mobile Day Treatment

B. CHILD INFORMATION: Complete for each restraint episode relating to a specific child.

Name of Child:

Last First Sex Date of Birth Social Security Number Name of CCYA/JPO

Legal Status of Child:

Alleged Delinquent Adjudicated Delinquent Alleged Dependent Adjudicated Dependent

C: DATE/TIME OF RESTRAINT:

DATE: ____ / ____ / ____

TIME: ____ : ____ AM / PM

D. TYPE(S) OF RESTRAINT: Check all that apply, as defined at §3800.209-.211.

Chemical Mechanical Manual

E. DESCRIPTION OF RESTRAINT: See instructions. (Use additional sheets if necessary).

Empty box for description of restraint.



pennsylvania

DEPARTMENT OF PUBLIC WELFARE

OFFICE OF CHILDREN, YOUTH AND FAMILIES

**PREGNANT FEMALES RESTRAINT REPORTING FORM
CHILD RESIDENTIAL AND DAY TREATMENT FACILITIES
TITLE 55 PA CODE CHAPTER 3800**

F. ACTION TAKEN: See instructions. (Use additional sheets if necessary).

[Empty space for reporting action taken]

G. NOTIFICATION:

_____	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date ____ / ____ / _____	Time ____ : ____	<input type="checkbox"/> AM <input type="checkbox"/> PM
Parent/Guardian/Custodian				
_____	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date ____ / ____ / _____	Time ____ : ____	<input type="checkbox"/> AM <input type="checkbox"/> PM
Parent/Guardian/Custodian				
_____	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date ____ / ____ / _____	Time ____ : ____	<input type="checkbox"/> AM <input type="checkbox"/> PM
Parent/Guardian/Custodian				
_____	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date ____ / ____ / _____	Time ____ : ____	<input type="checkbox"/> AM <input type="checkbox"/> PM
CCYA/JPO				
_____	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date ____ / ____ / _____	Time ____ : ____	<input type="checkbox"/> AM <input type="checkbox"/> PM
Regional Office of DPW				

H. CONTACT INFORMATION:

Name of person completing report:

Last First MI Title

Signature of Reporter Date Signature of Supervisor Date

Contact Person Name Contact Person Telephone #



A. FACILITY INFORMATION

Enter the name and address of the legal entity. If the facility name or address differs from that of the legal entity, enter the facility name or address. Enter the certificate of compliance number and the county in which the facility is located. Specify the type of facility from the options listed on this form in section A.

B. CHILD INFORMATION

Enter all identifying information regarding the child, including full name; sex, date of birth; social security number; and name of the County Children & Youth Agency, CCYA, or Juvenile Probation Office, JPO, involved with the youth. Specify the legal status of the child from the options listed on this form in section B.

C. DATE/TIME OF RESTRAINT

Enter the date and time the restraint occurred.

D. TYPE OF RESTRAINT

Specify the types of restraint(s) used. Check all that apply.

E. DESCRIPTION OF RESTRAINT

Complete a separate PREGNANT FEMALES RESTRAINT REPORTING FORM for each restraint episode. Enter descriptive information regarding:

- Description of circumstance that led to the restraint(s);
- Circumstances that led to the determination to restrain;
- Type of restraint(s) applied;
- Narrative description of the restraint(s) applied;
- Date, time, duration of restraint(s) and location of where restraint(s) occurred;
- Name of staff person(s) who applied the restraint(s);
- Name of staff person(s) who observed the child during the restraint(s); and
- Child's condition following the restraint(s).

F. ACTION TAKEN

Enter descriptive information regarding:

- De-briefing activities;
- Medical treatment, if provided; and
- Plan for intervention to reduce or eliminate restraints.

G. NOTIFICATION

Indicate whether or not the people listed on this form in section G were notified of the restraint; enter the date and time that they were notified.

H. CONTACT INFORMATION

Enter the name and title of the person completing this report; have the person completing the report and their respective supervisor sign and date the form; provide a contact name and telephone number.