

Critical Incident Report Form

SECTION A: FIRST RESPONDER(S) DETAILS

Name of person reporting the incident:	
Student <input type="checkbox"/> Staff <input type="checkbox"/> Other <input type="checkbox"/>	If other, please give contact email:
Date of this report: ___ / ___ / _____	

SECTION B: STUDENT DETAILS*

Name:	Student identification number (ID):
Date of Birth:	Address:
Contact number:	Home country:
Has contact been made with the student's next of kin/ emergency contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**If there is more than one student involved, please fill out a separate form for each student.*

SECTION C: INCIDENT DETAILS

This is the section where you fill out the details of the incident.

Date and time

When did the incident occur? If unsure, please select 'unknown'.

Date: ___ / ___ / _____	Time: ___ : ___ AM/PM	<input type="checkbox"/> Unknown
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Location

Did the incident occur on or off campus? <input type="checkbox"/> On campus <input type="checkbox"/> Off campus <input type="checkbox"/> Online
What was the exact location of the incident (if known)? For example, the street address and the description of the place the event occurred at or web address if incident occurred online.
Address:
Description of place:
<input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable

Type

Please select the category that best represents the critical incident, choose only one.

- | | |
|--|---|
| <input type="checkbox"/> Critical mental health episodes | <input type="checkbox"/> Missing students |
| <input type="checkbox"/> Death, serious injury or any threats of these | <input type="checkbox"/> Physical or other abuse or assault |
| <input type="checkbox"/> Domestic violence | <input type="checkbox"/> Serious accidents |
| <input type="checkbox"/> Drug, alcohol, or other substance abuse | <input type="checkbox"/> Severe verbal or physical aggression |
| <input type="checkbox"/> Fire or natural disaster | |
| <input type="checkbox"/> Other, please specify: _____ | |

**For reporting sexual misconduct, please see our Sexual Misconduct Form*

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Incident details

Please provide a short description of what happened including other persons involved.

First aid

Did a first aider give treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No (Go to the next part) <input type="checkbox"/> Unknown (Go to the next part)
Name of the first aider who gave treatment:
What treatment did the first aider give?

Emergency services

Were emergency services involved/called? <input type="checkbox"/> Yes <input type="checkbox"/> No (Go to the next part)
What service was initially called/involved? <input type="checkbox"/> Ambulance <input type="checkbox"/> Fire department <input type="checkbox"/> Police

Other actions and outcomes

Were there any other actions taken at the initial response?

SECTION D: SIGNATURE

Reporter's Signature:	Date: ___ / ___ / ___
Director Name:	
Director's Signature:	Date: ___ / ___ / ___