



## HARASSMENT AND/OR BULLYING COMPLAINT FORM

The purpose of this form is to document an incident or series of incidents of bullying and/or harassment so we can investigate and take appropriate steps. **For parents, if you or your child feel that they are unsafe, speak directly with the principal/Dignity Act coordinator in your building immediately and then fill out this form.**

Today's Date: \_\_\_\_\_ Building: \_\_\_\_\_

**Name of target** (student being bullied, harassed, or discriminated against):

\_\_\_\_\_

Student ID: \_\_\_\_\_ Grade: \_\_\_\_\_ Home District: \_\_\_\_\_

**Name of person reporting incident:** \_\_\_\_\_

Role of person reporting incident (check one):

☐ Student Target    ☐ Student (Witness)    ☐ Parent/Guardian    ☐ Staff Member    ☐ Other

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Relationship to the student (target): ☐ Self    ☐ Parent    ☐ Teacher    ☐ Student Peer

☐ Other (*please explain*) \_\_\_\_\_

**Name(s) of alleged offender(s)** (include grade and school, if known):

\_\_\_\_\_

\_\_\_\_\_

Date of Incident: \_\_\_\_\_ Time of Incident (Approx.): \_\_\_\_\_

What was your involvement in the incident?

☐ I was directly involved in the incident    ☐ I observed the incident

☐ I heard about the incident. If so, who did you hear about the incident from? \_\_\_\_\_

**Names of others who may have witnessed the incident:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**Where did the incident happen?** (Check all that apply):

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> On school property               | <input type="checkbox"/> Cafeteria            | <input type="checkbox"/> Hallway                  |
| <input type="checkbox"/> Classroom                        | <input type="checkbox"/> Gym                  | <input type="checkbox"/> Locker Room              |
| <input type="checkbox"/> Bathroom                         | <input type="checkbox"/> On a school bus      | <input type="checkbox"/> Parking Lot              |
| <input type="checkbox"/> Off school property              | <input type="checkbox"/> At a school function | <input type="checkbox"/> Electronic Communication |
| <input type="checkbox"/> Other ( <i>describe</i> ): _____ |   |   |

**Type of incident** (Check all that apply):

- ☐ Physical Contact (kicking, punching, spitting, tripping, pushing, taking belongings, etc.)
- ☐ Verbal threats (gossip, name-calling, put-downs, teasing, being mean, taunting, making threats)
- ☐ Psychological (non-verbal threats, spreading rumors, social exclusion, intimidation, etc.)
- ☐ Abuse (actions or statements that put an individual in fear of bodily harm)
- ☐ Cyberbullying (misusing technology/social media to harass, tease, threaten, post pictures (sexting), etc.)
- ☐ Other (*describe*): \_\_\_\_\_

**Who was involved in the incident?**

- ☐ Student                      ☐ Employee                      ☐ Both Student and Employee

**Describe the specific nature of the incident.** What happened? (Be as specific as possible). What did the alleged offender say or do? Include any copies of text messages, emails, etc. if possible.

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(Add extra pages as needed)

**If there were any adults in the area when this happened, what did they do?**

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**Type of bias involved (if known):**

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|--|--|---|
| <input type="checkbox"/> Race          | <input type="checkbox"/> Color           | <input type="checkbox"/> Religion                         |
| <input type="checkbox"/> Ethnic Origin | <input type="checkbox"/> National Origin | <input type="checkbox"/> Religious Practice               |
| <input type="checkbox"/> Sex           | <input type="checkbox"/> Gender          | <input type="checkbox"/> Sexual Orientation               |
| <input type="checkbox"/> Weight/Size   | <input type="checkbox"/> Disability      | <input type="checkbox"/> Other ( <i>describe</i> ): _____ |

**Did a physical injury result from this incident? (Check all that apply):**

- ☐ Yes (medical attention needed)    ☐ Yes (no medical attention needed)    ☐ No
- ☐ Evaluation by school nurse was completed
- ☐ Other medical intervention pursued (*please specify*): \_\_\_\_\_

**Does the situation continue to occur?**    ☐ Yes    ☐ No

**Has this happened before?**    ☐ Yes    ☐ No

Describe (if known): \_\_\_\_\_

**Has the student been absent from school as a result of the incident? (if known)**

- ☐ Yes    ☐ No        If yes, number of days student was absent: \_\_\_\_\_

**Describe the impact this incident has had on the student (target) (if known):**

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*I certify that all statements on this form are accurate and true to the best of my knowledge.*

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please return this completed form to your school's Dignity Act Coordinator or Principal.**

**You can contact your school administrator, Dignity Act coordinator, counselor, or other staff member (whoever you are most comfortable with) for information or assistance at any time.**



**DIGNITY FOR ALL STUDENTS ACT (DASA)  
INCIDENT INVESTIGATION FORM**

**\*\*FOR SCHOOL LEADERS OR DESIGNEE ONLY\*\***

**Dignity Act Coordinator:** \_\_\_\_\_ **Position:** \_\_\_\_\_

**Date Complaint Form Received:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**Results of Investigation** (include a summary of information gathered from interviews):

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(Add extra pages as needed)

**Did the investigation verify that a material incident of bullying, harassment, and/or discrimination occurred?**   ☐ Yes (Founded)   ☐ No (Unfounded)

**If no, please explain why:**

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**Description of plan to eliminate bullying and reduce the hostile environment:**

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**Date of contact with parents/guardians of target:** \_\_\_\_\_

**Date of contact with parents/guardians of aggressor(s):** \_\_\_\_\_

**Date of contact with law enforcement (if applicable):** \_\_\_\_\_

**Results of contact:** \_\_\_\_\_

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**Remediation:** (Check all that apply)

- ☐ Education/Counseling      ☐ Separation of Students
- ☐ Disciplinary (Code of Conduct application) \_\_\_\_\_
- ☐ Restorative Justice or other program \_\_\_\_\_
- ☐ Law Enforcement \_\_\_\_\_
- ☐ Other (*describe*): \_\_\_\_\_

**Who needs to be informed about the plan (respect confidentiality)?** (Check all that apply)

- ☐ Students    ☐ Administration    ☐ Parents    ☐ School Staff    ☐ Other \_\_\_\_\_

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Follow Up Review of Plan**

**After \_\_\_\_ weeks, is the plan working?** ☐ Yes    ☐ No

**Target's response to plan to determine effectiveness:**

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**Additional plan revisions and comments, if needed:**

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- **Keep this report on file to calculate yearly data reported to the New York State Education Department.**
- **Please submit a copy of this report to the Deputy District Superintendent for Curriculum and Instruction and the School Attorney at Capital Region BOCES, 900 Watervliet-Shaker Rd., Albany, N.Y. 12205**