GAELSCOIL FAITHLEANN

Anti- Bullying Programme

INCIDENT REPORT FORM

Source of Report: Tick ✓ as appropriate Parent ☐ Pupil ☐ Staff-Member ☐ Survey ☐ Other ☐

Date: ______________

Name of Reporting Person (if applicable):

If Staff Member: ____

If Pupil: ____ Class: _______

If someone other than a Staff Member or Pupil:

Name of Reporting Person: ______________________ Phone: __________

Address: ____

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Details of Alleged Incident:

Location of incident: ____

Time: ______________ Day: ______________ Date: ______________

Possible Targeted Pupil(s): ______________________ Class/Group: __________

Possible Perpetrator(s): ______________________ Class/Group: __________

____ Class/Group: __________

Others who were there: ____

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Initial Details of Incident: ____

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Action taken will be outlined on reverse