



LEVITTOWN PUBLIC SCHOOLS

Student Bullying Report Form



STOP BULLYING

Instructions:

Please complete **both** pages, responding only to the questions that you feel comfortable answering and are able to accurately answer. Please include your name at the bottom of the form; the District's ability to investigate an anonymous complaint is limited.

The District prohibits retaliation against anyone who files a bullying report.

Describe what happened / what is happening:

When did it happen?

- Before school
 During school
 After school
 Unsure

Date:

Time:

 am pm

Where did it happen?

- School building (list specific room):
 On the school playground
 In the school parking lot
 On the school bus
 Online

At a school event (list specific event):

Other (please specify):

Unsure

Who was committing the bullying (if you don't know the bully's name(s) describe him/her)?

Who was the victim of the bullying (if you don't know his/her name, describe him/her)?

Did anyone else witness the bullying (if yes, please list)?

- Yes
 No
 Unsure

Were you or others physically hurt (please explain)?

- Yes
 No
 Unsure

Was there damage to anyone's personal property? Explain what was damaged.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	
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Have you or the victim missed any school or made any changes to your daily routine as a result of the incident(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	
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Have you told anyone about the bullying?	<input type="checkbox"/> Parent <input type="checkbox"/> Babysitter <input type="checkbox"/> Brother/sister <input type="checkbox"/> Other family member:	<input type="checkbox"/> Teacher <input type="checkbox"/> Other school staff: <input type="checkbox"/> Other:
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Have you previously filed a bullying report (this information is used to determine if retaliation is occurring)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
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Your name:	
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Your grade and age:	
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How can we contact you?	<input type="checkbox"/> Phone:	
	<input type="checkbox"/> Email:	
	<input type="checkbox"/> Other:	