

San Diego Unified School District  
**SUSPECTED CHILD ABUSE REPORT**

To Be Completed by **Mandated Child Abuse Reporters**

Pursuant to Penal Code Section 11166

PLEASE PRINT OR TYPE

CASE NAME: \_\_\_\_\_

CASE NUMBER: \_\_\_\_\_

<b>A. REPORTING PARTY</b>	NAME OF MANDATED REPORTER		TITLE		MANDATED REPORTER CATEGORY					
	REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS Street _____ City _____ Zip _____				DID MANDATED REPORTER WITNESS THE INCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					
	REPORTER'S TELEPHONE (DAYTIME) ( ) -		SIGNATURE		TODAY'S DATE					
<b>B. REPORT NOTIFICATION</b>	<input type="checkbox"/> LAW ENFORCEMENT <input type="checkbox"/> COUNTY PROBATION <input type="checkbox"/> COUNTY WELFARE/CPS (Child Protective Services)		AGENCY							
	ADDRESS Street _____ City _____ Zip _____				DATE/TIME OF PHONE CALL					
	OFFICIAL CONTACTED - TITLE				TELEPHONE ( ) -					
<b>C. VICTIM One report per victim</b>	NAME (LAST, FIRST, MIDDLE)			BIRTHDATE OR APPROX. AGE		SEX	ETHNICITY			
	ADDRESS Street _____ City _____ Zip _____			TELEPHONE ( ) -						
	PRESENT LOCATION OF VICTIM			SCHOOL		CLASS	GRADE			
	PHYSICALLY DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DEVELOPMENTALLY DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO		OTHER DISABILITY (SPECIFY)		PRIMARY LANGUAGE SPOKEN IN HOME				
	IN FOSTER CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: <input type="checkbox"/> DAY CARE <input type="checkbox"/> CHILD CARE CENTER <input type="checkbox"/> FOSTER FAMILY HOME <input type="checkbox"/> FAMILY FRIEND <input type="checkbox"/> GROUP HOME OR INSTITUTION <input type="checkbox"/> RELATIVE'S HOME			TYPE OF ABUSE (CHECK ONE OR MORE) <input type="checkbox"/> PHYSICAL <input type="checkbox"/> MENTAL <input type="checkbox"/> SEXUAL <input type="checkbox"/> NEGLECT <input type="checkbox"/> OTHER (SPECIFY)					
	RELATIONSHIP TO SUSPECT			PHOTOS TAKEN? <input type="checkbox"/> YES <input type="checkbox"/> NO		DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				
<b>D. INVOLVED PARTIES</b>	<b>VICTIM'S SIBLINGS</b>									
	NAME		BIRTHDATE	SEX	ETHNICITY	NAME		BIRTHDATE	SEX	ETHNICITY
	1.					3.				
	2.					4.				
	<b>VICTIM'S PARENTS/GUARDIANS</b>									
	NAME (LAST, FIRST, MIDDLE)			BIRTHDATE OR APPROX. AGE		SEX	ETHNICITY			
	ADDRESS Street _____ City _____ Zip _____			HOME PHONE ( ) -		BUSINESS PHONE ( ) -				
	NAME (LAST, FIRST, MIDDLE)			BIRTHDATE OR APPROX. AGE		SEX	ETHNICITY			
	ADDRESS Street _____ City _____ Zip _____			HOME PHONE ( ) -		BUSINESS PHONE ( ) -				
	<b>SUSPECT</b>									
SUSPECT'S NAME (LAST, FIRST, MIDDLE)			BIRTHDATE OR APPROX. AGE		SEX	ETHNICITY				
ADDRESS Street _____ City _____ Zip _____			TELEPHONE ( ) -							
OTHER RELEVANT INFORMATION										
<b>E. INCIDENT INFORMATION</b>	IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX <input type="checkbox"/>				IF MULTIPLE VICTIMS, INDICATE NUMBER: _____					
	DATE / TIME OF INCIDENT			PLACE OF INCIDENT						
	NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)									