



# FACULTY/STAFF- STUDENT CHEMICAL IMPAIRMENT OBSERVATION FORM

STUDENT NAME: \_\_\_\_\_ UIN: \_\_\_\_\_

DATE & TIME: \_\_\_\_\_

LOCATION OF OBSERVATION: \_\_\_\_\_

NAME & PHONE NUMBER OF OBSERVER: \_\_\_\_\_

ODOR (ALCOHOL OR OTHER SUBSTANCE)	<input type="checkbox"/> STRONG	<input type="checkbox"/> MODERATE	<input type="checkbox"/> FAINT	<input type="checkbox"/> NONE	<input type="checkbox"/> OTHER (Describe) _____	
UNUSUAL ACTION	<input type="checkbox"/> FIGHTING	<input type="checkbox"/> CRYING	<input type="checkbox"/> HICCUPING	<input type="checkbox"/> NONE	<input type="checkbox"/> BELCHING/VOMITING <input type="checkbox"/> OTHER (Describe) _____	
SPEECH	<input type="checkbox"/> MUMBLED	<input type="checkbox"/> STUTTERED	<input type="checkbox"/> SLURRED	<input type="checkbox"/> CONFUSED	<input type="checkbox"/> INCOHERENT <input type="checkbox"/> OTHER (Describe) _____	
BALANCE	<input type="checkbox"/> SUPPORTED	<input type="checkbox"/> WOBBLING	<input type="checkbox"/> SWAYING	<input type="checkbox"/> FALLING	<input type="checkbox"/> OTHER (Describe) _____	
WALKING	<input type="checkbox"/> STAGGERING	<input type="checkbox"/> SWAYING	<input type="checkbox"/> STUMBLING	<input type="checkbox"/> FALLING	<input type="checkbox"/> OTHER (Describe) _____	
ATTITUDE	<input type="checkbox"/> ARGUMENTATIVE	<input type="checkbox"/> UNCOOPERATIVE	<input type="checkbox"/> COMBATIVE	<input type="checkbox"/> INSULTING	<input type="checkbox"/> OTHER (Describe) _____	
PHYSICAL APPEARANCE	<input type="checkbox"/> FLUSHED/SWOLLEN FACE	<input type="checkbox"/> RUNNY NOSE	<input type="checkbox"/> USING BREATH FRESHENERS	<input type="checkbox"/> RED/WATERY EYES	<input type="checkbox"/> SHAKING/NERVOUS	<input type="checkbox"/> OTHERS (Describe) _____
INAPPROPRIATE ACTIONS	<input type="checkbox"/> PERFORMANCE	<input type="checkbox"/> MOOD SWINGS	<input type="checkbox"/> JUDGEMENT	<input type="checkbox"/> OTHER (Describe) _____		

**Below- please complete a written narrative, in your own words, of the events that occurred. Include what you saw, heard, or smelled.**

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PRINTED NAME OF FACULTY OR STAFF: \_\_\_\_\_

SIGNATURE OF FACULTY OR STAFF: \_\_\_\_\_

**\*\*Please complete this form as soon as possible after incident occurred. (timeliness is very important in these situations).\*\***

**Once form is completed, scan and email to the Campus Safety Director on your campus.**