

Medication Administration Incident Report

Student's Name _____			
<i>Last Name</i>	<i>First Name</i>	<i>Middle Initial</i>	
Student's Address _____			
<i>City</i>		<i>State</i>	<i>ZIP Code</i>
Student's Age _____	Date of Birth _____	Student's Phone Number _____	
Grade _____	School Name _____		

TO BE COMPLETED IN INK BY SCHOOL PERSONNEL IN THE EVENT THAT AN ERROR IS MADE IN ADMINISTRATION OF MEDICATION

Name of person administering medication: _____

Name of medication/dosage/route prescribed: _____

Time(s) to be given: _____

Type of medication error: (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Medication administered to incorrect student | <input type="checkbox"/> Medication administered at incorrect time |
| <input type="checkbox"/> Incorrect dosage of medication administered | <input type="checkbox"/> Incorrect medication administered |
| <input type="checkbox"/> Incorrect documentation provided | <input type="checkbox"/> Other |

Description of error: _____

Date and time of error: _____ AM PM

Dosage given: _____

Describe circumstances leading to error: _____

Explain action taken: _____

Reaction(s): _____

- Persons notified of error: School Principal School nurse, if appropriate Physician
 Poison Control Center Parent/Guardian
 Other, _____

Signature of Person Completing the Report

Date

Principal's Signature

Date

Follow-up notes, if applicable: _____