Medication Administration Incident Report

Student's Name _____ _____ _____
Last Name *First Name* *Middle Initial*

Student's Address _____ _____ _____
City *State* *ZIP Code*

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)

☐ Medication administered to incorrect student ☐ Medication administered at incorrect time

☐ Incorrect dosage of medication administered ☐ Incorrect medication administered

☐ Incorrect documentation provided ☐ 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: _____