

**MEDICATION ADMINISTRATION INCIDENT REPORT FORM**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

School Name: \_\_\_\_\_ Grade \_\_\_\_\_

Date/Time of Error: \_\_\_\_\_

Name of person administering medication: \_\_\_\_\_

Name of medication \_\_\_\_\_ Dosage \_\_\_\_\_ Route \_\_\_\_\_

Time(s) to be given: \_\_\_\_\_

Type of medication error:

Wrong Student

Wrong Route

Wrong Time

Wrong Medication

Wrong Dose

Wrong Documentation

Describe the error: \_\_\_\_\_

\_\_\_\_\_

Action Taken/Intervention:

Called Poison Control - 589-8222 or 1-800-222-1222

Notified the following people:

Principal \_\_\_\_\_ (principal's signature) **REQUIRED**

School Nurse or Cluster Nurse Practitioner/Health Services – **REQUIRED**

Called report to \_\_\_\_\_ (name of person) 485-3387

**AND**

Faxed to Health Services \_\_\_\_\_ (date and time) 485-3670

Parent or Guardian - **REQUIRED**

CPR/First Aid Responder

Other Interventions/Notes \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of Person Completing Report: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Follow Up Care (if applicable): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_