

MEDICATION ADMINISTRATION ERROR INCIDENT REPORT

Student's Name _____ Grade _____

Date of Occurrence _____ Time _____ ()AM ()PM

Staff Member in Charge at the Time of Error _____

Medication _____ Dosage _____

Method of Administration _____

Prescribed Time of Administration _____ ()AM ()PM

Name of Provider Prescribing the Medication _____

Describe the Event: (This section must be completed by the staff member making the error) (Please be thorough in description. Remember right student, right medication, right dose, right time and right method of administering the medicine. Address each in describing the error)

Identify any contributing factor(s):

Notifications when error was realized (if needed):

School Nurse () YES () NO Date _____ Time _____ ()AM ()PM

Principal () YES () NO Date _____ Time _____ ()AM ()PM

Parent () YES () NO Date _____ Time _____ ()AM ()PM

Medication Provider () YES () NO Date _____ Time _____ ()AM ()PM

Outcome of Incident:

Student was observed, no intervention was required

Some temporary or localized response, no medical intervention required Describe :

Student required medical attention Describe: _____

Student required EMT assistance () and transport to hospital

Other, please explain in detail:

Name of person preparing report _____
(print)

Signature _____

6/13/23