

MEDICATION INCIDENT REPORT

NAME: _____ STUDENT NUMBER: _____
LAST FIRST M.

SCHOOL NAME: _____ SCHOOL LOCATION #: _____

HOME ADDRESS: _____ ZIP CODE: _____

GRADE: _____ BIRTHDATE: _____ SEX: MALE _____ FEMALE _____

TIME OF INCIDENT: _____ DATE OF INCIDENT: _____

TYPE OF INCIDENT: (CIRCLE)

Wrong dosage Wrong student Wrong medication Wrong time Unable to locate student

Reported by: _____
NARRATIVE DESCRIPTION:

PARENT/GUARDIAN Notification YES[] NO[] By Whom _____	Date _____	Time _____
Comments:		

MD notification YES[] NO[] By Whom _____
Comments:

Poison Control notified: (272-2222 or 1-800-432-6866) YES[] NO[] Recommendations: _____

ACTIONS/OBSERVATIONS:

RECOMMENDED PLAN OF ACTION

PLAN OF ACTION COMPLETED

Signature: _____ Date: _____ Time: _____
 Supervising Nurse: _____ Date: _____
 Principal: _____ Date: _____

COPIES: RISK MANAGEMENT
 CUM FOLDER
 NURSING SERVICES
 NURSE/TEACHER