MEDICATION INCIDENT REPORT

Instructions: *To be completed as soon as possible after the incident occurred and appropriate response actions/interventions were taken. File form with the building principal.*

Date of Report: _____
Name of person completing this report: _____
Student's name: _____
Date of birth: _____ Grade: _____
Date incident occurred: _____ Time: _____ ☐am ☐pm
Person providing medication: _____
Name of medication: _____
Regular dose: _____ regularly scheduled time: _____

TYPE OF INCIDENT

- ○ Forgot to document the medication by the end of school day on which the medication was provided
- ○ Forgot to give a dose of medication
- ○ Gave the medication at the wrong time
- ○ Gave the medication by the wrong route
- ○ Gave the wrong dose of the medication
- ○ Gave the wrong medication
- ○ Gave the medication to the wrong child
- ○ Student refused a dose of medication
- ○ Other: _____

Provide a summary of the incident and describe how it occurred:

_____
_____
_____

ACTION TAKEN/INTERVENTION

School Administrator notified: ○Yes, Date: _____ Time: _____ ○No ○N/a
Parent/Guardian notified: ○Yes, Date: _____ Time: _____ ○No
If yes, name of the parent/guardian who was notified: _____
Student's emergency contact alternate notified: ○Yes, Date: _____ Time:_____○No
911 Called: ○Yes ○No
Student's healthcare provider contacted: ○Yes, Date: _____ Time: _____ ○No
If yes, student healthcare provider's name_____
Describe interventions taken and outcome:

_____
_____
_____

FOLLOW-UP AND PREVENTION (To be completed by building principal)
List any follow-up information related to the incident and prevention measures enacted to prevent similar incidents in the future:

_____

_____

Building administrator's signature: _____ Date:_____

End of Dickinson Public Schools ACBD-E8