Valley School District

Medication Administration Incident Report

Student/Child Name:_____ Birthdate:_____

Person administering medication:_____School: _____

Date and time of error: _____

Medication: _____ Dosage:_____

Mode of Admin.:_____ Time(s) to be given: _____

Circle all details that describe this medication error:

Wrong student	Wrong time	Wrong dose
Wrong mode	Wrong medication	Wrong documentation

Describe the error (T*he person making the error should write this. If the wrong medication was given, include the medication name and dosage given.*)

_____

_____

_____

_____

Describe the action taken and/or intervention: _____

_____

_____

_____

Persons notified at time of error:

_____Date/time of notification: _____

_____Date/time of notification: _____

_____Date/time of notification: _____

Student's Licensed Healthcare Provider notified:_____

Date/time of notification: _____

Follow-up care or information (if applicable): _____

_____

_____

_____

_____

Name of person completing incident report:_____

Signature: _____ Date:_____