MEDICATION ERROR REPORT

Student Name_______________________DOB__________School____________Grade__
Date of Error ___/___/___ Time of Error ______________________________

Location of Error: _____ Health Room ______ Classroom _____Off site _____Other

Staff involved: ___RN ___Health Clerk ___Teacher ___Substitute ___Office Staff __Other

Medical Diagnosis:____

Prescribed Medication Name_______________ Dose:________________ Route:____________

Response Observed: ____

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Student Condition Prior to Occurrence:____

1. Alert/normal 2. Agitated 3. Unresponsive
4. Lethargic 5. Able to communicate needs? If no, Explain___________

Medication Variance: Medication/Dose/Route___________________________________

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Variance: _____________________________Explain: _____________________________

1. Medication Missing 4. Medication charted but not given 7. Wrong Route
2. Adverse side effects 5. Duplication/Extra Dose given 8. Wrong Dose
3. Med. Given but not charted 6. Time Variance (> 1 hour) 9. Wrong student

Procedural Variance:__________________ Explain:______________________________

1. Performed on wrong student 4. Staff not available 7. Authorization not signed
2. Improper preparation of student 5. Procedure omitted 8. Security problem
3. Student was NOT on time 6. Supplies/Equipment unavailable/inoperable

Name/Title of person responsible for occurrence:_______________________________

NOTIFICATION: Parent/Guardian called: Date:__________________Time:___________
Parent/Guardian arrived Date:__________________ Time:___________

Parent/Guardian Response: ____

Physician notified: Date:_________ Time:__________ Spoke with: _______________________

911 called: Time: __________ Arrived on scene:_______________________________________

Administrator notified: _________________________Date: __________Time: __________

School Nurse notified: _________________________ Date: __________Time:__________

Report completed by (Name/Title): ___________________________________Date:______

Reviewed by (Name/Title): ____ Date:______

REPORT OF MEDICATION ERROR

Name of School ______________________ Date and Time of Error ______________________

Name of Student ______________________ Birth Date ______________________

Name/Position of person administering Med. ______________________ Prescribed medication/ Dosage/ Route/ Time ______________________

Describe error and circumstances leading to error: ______________________

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Describe action taken: ______________________

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Persons notified of error:

	Name	Date	Time
Principal			
Parent			
Physician			
School Health Coordinator			
Other			

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Signature (person completing report) Date Completed

Follow-up information, if applicable (to be completed by School Health Coordinator)

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Revised 3/07 Original: School Health Coordinator Copy: Building Principal