Incident Report Medication Administration

*This form is to be completed whenever any one of the “Rights” of Medication Administration is not in place.

Child’s Name:	Birthdate:	School/Child Care:	Classroom:
Name of medication:	Dose:	Time to be given:	Route:
Incident discovered by: Date: Time:			
Person completing this form: Signature:			

*Please describe the INCIDENT below. Always inform the Child Care Health Consultant or School Nurse of this situation. If the student was injured during this incident, further documentation and reporting will be required.

	Describe the Exceptional Situation	**Describe Action/Follow-Up Taken**
Right Student?		
Right Medication?		
Right Dose?		
Right Route?		
Right Time?		
Right Documentation?		
Right Order? Signed/dated by Parent & Doctor? Plan or med expired?		
Communication:	☐ Parent Notified: Date/Time: _____ ☐ Nurse Notified: Date/Time: _____	☐ Principal/Director Notified: Date/Time: _____ ☐ If needed, 911 or Poison Control Notified: Date/Time: _____

Nurse comments/corrective action: Nurse signature/date: