JEFFERSON COUNTY PUBLIC SCHOOLS
MEDICATION ADMINISTRATION INCIDENT REPORT FORM

Student Name: _____ **DOB:**_____

School Name:_____ **Grade:**_____

Date/Time of Error:_____

Name of Person Administering Medication: _____

Name of Medication: _____ **Dosage:**_____ **Route:**_____

Time(s) to Be Given:_____

Type of Medication Error:

___Wrong Student **___Wrong Route**

___Wrong Time **___Wrong Medication**

___Wrong Dose **___Wrong Documentation**

Describe the Error:_____

_____

_____

Action Taken/Intervention:

___Called Poison Control - 589-8222 or 1-800-222-1222

___Notified the Following People:

___Principal _____**(Principal's signature) REQUIRED**

___School Nurse or Area Nurse Practitioner/Health Services – REQUIRED

___Called Report to _____**(name of person) 485-3387**

AND

___Faxed to Health Services _____ **(date and time) 485-3670**

___Parent or Guardian - REQUIRED

___CPR/First Aid Responder

___Other Interventions/Notes_____

_____

_____

_____

Name of Person Completing Report: _____

Signature: _____ **Date:** _____

Follow Up Care (if applicable): _____

_____

Revised April 19, 2014