

Chippewa Valley Schools

Medication Incident/Error Report Form

Date of Report: _____ School: _____ Prepared By: _____

Name of Student: _____ Date of Birth: _____ Grade: _____

Parents Name: _____ Phone Number: _____

Date Error Occurred: _____ Time Noted: _____

Person Administering Medication: _____

Licensed Prescriber: (Name) _____ (Phone Number) _____

Medication: _____ Dose: _____ Route: _____

Scheduled Time: _____ Frequency: _____ Date of Order: _____

Instructions for Administration: _____

Type of Error:

1. Time: _____
2. Medication: _____
3. Dose: _____
4. Route: _____
5. Contamination/Destruction: _____
6. Documentation: _____
7. Incorrect student received medication: _____

Description of Error in Detail (Use reverse side if necessary)

Action Taken

Licensed Prescriber Notified: Yes: No: Date: _____ Time: _____ Name: _____

Parent/Guardian Notified: Yes No: Date: _____ Time: _____

Other Persons Notified: _____

Signature of Person Preparing Report: _____

Follow-up Contact/Care: _____