



TITLE:
Medication Incident Report

FORM: JHCD-R-F(4)

Updated 8/14/2020

School Name _____

In all cases, this form should be prepared by the school nurse or health assistant and signed by the school principal. The original will be sent to Health Services. A copy will be retained by the principal and/or nurse/health assistant.

Student's Name _____ Birth Date _____ Phone _____

Address _____ Street _____ City _____ Zip _____ Grade _____ Room _____

Place of Incident _____ Date of Incident _____ Time Noted _____

Name of Prescribing Physician _____

Medication _____ Dose _____ Route _____

Describe the incident, including the sequence of events and names of persons involved:

Action Taken: Parent/Guardian Notification Required

Parent/Guardian Contact Attempted at _____ Parent/Guardian Contacted at _____

Poison Control Contacted _____ YES _____ NO Pharmacist Contacted _____ YES _____ NO

Physician Contacted _____ YES _____ NO

Where Taken After Incident _____
(Specify home, physician, hospital—give name and address)

By Whom _____ At What Time _____

Describe the outcome: _____

Date of Report _____ Health Assistant Signature _____

Nurse Signature _____ Principal Signature _____