The Defining Difference

HEALTH SERVICES
MEDICATION INCIDENT REPORT

Date: _____ School: _____

Student: _____ DOB: _____

Date and Time of incident: _____

Person administering/assisting with the self-administration of the medication: _____

_____

Medication and dosage prescribed: _____

Describe incident: _____

_____

Describe action taken: _____

_____

*Use Nurses Notes (HEA-F017) for additional documentation if needed and send in with this form.

Persons notified of incident: District Registered Nurse *(920-7976)* / *Safety and Health Department (920-7836)*:

_____ Time: _____

Principal _____ Time: _____

Parent _____ Time: _____

Physician (if applicable) _____ Time: _____

Poison Control at 1-800-222-1222 _____ Time: _____

_____ _____

Signature of person completing report — Date

_____ _____

PRINT name of person completing report — Title

Forward copy of this report IMMEDIATELY upon completion to District Registered Nurse via fax (905-7908) or scanned to email at Brittney.kirk@cmcss.net