VALLEY CITY PUBLIC SCHOOL DISTRICT #2 VALLEY CITY, NORTH DAKOTA 58072 MEDICATION INCIDENT REPORT	Descriptor Code ACBD-E9	1st Reading 8/9/18
	Adopted 8/9/18	Revised/Rescinded

MEDICATION INCIDENT REPORT

Instructions: *To be completed as soon as possible after the incident occurred and appropriate response actions/interventions were taken. File form with the building principal.*

Date of Report:_____
Name of person completing this report: _____
Student's name: _____
Date of birth:_____ Grade: _____
Date incident occurred: _____Time: _____ ☐am ☐pm
Person providing medication: _____
Name of medication: _____
Regular dose: _____ Regularly scheduled time: _____

TYPE OF INCIDENT

☐ Forgot to document the medication by the end of school day on which the medication was provided
☐ Forgot to give a dose of medication
☐ Gave the medication at the wrong time
☐ Gave the medication by the wrong route
☐ Gave the wrong dose of the medication
☐ Gave the wrong medication
☐ Gave the medication to the wrong child
☐ Student refused a dose of medication
☐ Other: _____

Provide a summary of the incident and describe how it occurred:_____
_____

ACTION TAKEN/INTERVENTION

School nurse notified: ☐Yes, Date: _____ Time: _____ ☐No ☐N/a
Parent/Guardian notified: ☐Yes, Date: _____ Time: _____ ☐No
If yes, name of the parent/guardian who was notified: _____
Student's emergency contact alternate notified: ☐Yes, Date: _____Time: _____ ☐No

911 Called: ☐Yes ☐No
Student's healthcare provider contacted: ☐Yes, Date: _____ Time:_____☐No
If yes, student healthcare provider's name: _____

Describe interventions taken and outcome:_____
_____

FOLLOW-UP AND PREVENTION (To be completed by building principal)
List any follow-up information related to the incident and prevention measures enacted to prevent similar incidents in the future:_____
Building administrator's signature:_____
Date: _____