Incident Report Medication Administration

This form is to be completed whenever any one of the "Rights" of Medication Administration is not in place.

Child's Name:	Birthdate:	School/Child Care:	Classroom:
Name of Medication:	Dose:	Time to be given:	Route:
Date and Time Incident Discovered:			
Person Completing this Form:			

Please describe the INCIDENT below. Always inform the Child Care Health Consultant or School Nurse of this situation. If the student was injured during this incident, further documentation and reporting will be required.

	Describe the Exceptional Situation	**Describe Action/Follow-Up Taken**
Right Student		
Right Medication		
Right Dose		
Right Route		
Right Time		
Right Documentation		
Right written orders signed and dated by parent and doctor		
Communication:		☐ Parent Notified: Date/Time: _____ ☐ Nurse Notified: Date/Time: _____ ☐ Principal/Director Notified: Date/Time: _____ ☐ if needed, 911 or Poison Control Notified: Date/Time: _____

Nurses Comments/Corrective Action Taken:

CCHC/SN: _____ Date: _____