ACBD-E9 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: _____

New Town Public School District #1

Exhibit Approved: January 12, 2016