

**MEDICATION INCIDENT REPORT**

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| **Child’s Name:** |  |
| **Date of Report:** |  |
| **Name of Person Completing This Report:** |  |
| **Date and Time of Incident:** |  |
| **Name of Person Administering Medication:** |  |
| **Name of Medication:** |  |
| **Dosage:** |  |
| **Scheduled Time:** |  |

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| **Described the error and how it occurred:** |
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| **Action Taken/Intervention:** |
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| **Parent contacted?** | Yes No How?Phone Other\_\_\_\_\_ |
| **Name of Parent contacted:** |  |
| **Follow Up and Outcome:** |  |

Signature of Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_