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 Danielle.Kriminger@cmcss.net