

MEDICATION ERROR REPORT

Date _____ School _____ Prepared By _____

Name of Student _____

Date of Birth _____ Sex _____ Grade _____

Home Address _____

Phone Number _____

Date Error Occurred _____ Time Noted _____

Person Administering Medication _____ Position _____

Licensed Prescriber _____

Address _____ Phone _____

Reason Medication was Prescribed _____

Date of Order _____ Instructions for Administration _____

Medication Name _____ Dose _____ Route _____ Scheduled Time _____

Describe the error and how it occurred (use reverse side if necessary)

Action Taken

Licensed Prescriber Notified: Yes ___ No ___ Date _____ Time _____

Parent/Guardian Notified: Yes ___ No ___ Date _____ Time _____

Other Persons Notified: _____

Outcome: _____

Name: _____ Date _____

Signature _____ Title _____

First reading 2015 revision: November 2, 2015

Second reading: December 7, 2015

Third Reading/Adoption: December 14, 2015

Proposed reconsideration: December 2020

Hull Public Schools