DELAWARE CITY SCHOOLS

INCIDENT REPORT – MEDICATION ADMINISTRATION

Name of Student: _____

Name of School: _____

Date and Time of Error: _____

Name of Person Administering Medication: _____

Name of Medication, Strength Prescribed: _____

Describe Circumstances Leading to Error:

_____

_____

_____

Describe Action Taken:

_____

_____

Persons Notified of Error:
Nurse: _____
Principal: _____
Parent: _____
Licensed Prescriber (if applicable): _____
Other: _____

Signature of Person Completing Report: _____ Date: _____

Follow-up Information: _____

Incident Reviewed by School Nurse: _____

Action Taken to Prevent Future Incidents: _____

_____

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_____

This Report is for Internal Use Only.

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