



MEDICATION ERROR REPORT FORM

Student: _____ DOB: _____

School: _____ Date of Error: _____

Medication: _____ Dose prescribed: _____

Person Administering Medication: _____

Type of error: _____

Describe the circumstances leading to the error:

Action/Intervention:

Notifications:

Parent: _____ Date of Notification: _____ Time of Notification: _____

Building Administrator: _____ Date of Notification: _____ Time of Notification: _____

Students Physician (if applicable): _____ Date of Notification: _____ Time of Notification: _____

District Nurse: _____ Date of Notification: _____ Time of Notification: _____

Follow up/Outcome:

Signature of person preparing report: _____ Date: _____