



**Inappropriate Administration of Medication Report**

DATE: \_\_\_\_\_

Incident Discovered By: \_\_\_\_\_

Student's Name: \_\_\_\_\_

Name of Medication and Dosage: \_\_\_\_\_

Prescribed Date and Time of Med: \_\_\_\_\_

Time Noticed: \_\_\_\_\_

Staff Responsible: \_\_\_\_\_

**Medication Incident:**

- \_\_\_\_\_ Omitted Dose
- \_\_\_\_\_ Incorrect Dose
- \_\_\_\_\_ Incorrect Client
- \_\_\_\_\_ Incorrect Medication
- \_\_\_\_\_ Incorrect Time
- \_\_\_\_\_ Incorrect Method
- \_\_\_\_\_ Other: \_\_\_\_\_

**PERSONS NOTIFIED**

Parent  
 Supervisor  
 Pharmacist\*  
 Doctor\*  
 Parent/Guardian  
 Staff Responsible  
 Other (Specify)

	IMMEDIATELY	WITHIN 24 HOURS	WITHIN 72 HOURS	OTHER (please specify)
Parent				
Supervisor				
Pharmacist*				
Doctor*				
Parent/Guardian				
Staff Responsible				
Other (Specify)				

\* If required depending on the nature of the incident.



Description of Incident:

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Pharmacist's Instructions ( if required):

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Supervisor/Coordinator's Comments:

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Follow-Up:

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Signature of Staff

Position

Staff Responsible:		
Discovered By:		
Supervisor		
Other		