MEDICATION ERROR REPORT

Contact District Health Service discovery. Fax report once					
Name of School	Date of Event	Time of Error	Error Code		
Name of Student/Student ID number	D.O.B.	Prescribed Me Medica	dication/Dosage/Ro ation Authorization F	ute/Time on orm	
Name and Position of Person Witnessing Event	Writ	e Medication/Do	osage/Route/Time G	GIVEN	
Describe error:					
Describe action(s) taken:					
Persons to be notified:	-			1	
Title		Name		Date	Time
Principal Parent					
Physician (if appropriate)					
Poison Control (if appropriate)1-800-222-1222					
RN Supervisor					
ALOA Coordinator					
District Health Services Coordinator 850-469-5456					
Signature (person completing report)			Date C	ompleted	
Follow-up Action by Supervisor (to be co	mpleted within	10 days):			
			Signature of Supervisor		
			9	•	
Medication Error Codes: 1. Wrong Student 2. Wrong Dose	3. Wrong Time 4. Wrong Med		Missed Medication Parent Error	7. Pharmacy I 8. Other	Error