LONG COUNTY SCHOOL HEALTH SERVICES
Medication Error Report

Name of school: ______________________ Date/time of occurrence: __________________________

Name of student: ________________________________ Birth date: ________________________

Name of person administering (or failing to administer) medication:____________________________

Name of medication and dosage prescribed: ____

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Describe action taken:____

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Persons notified of occurrence (name and time notified):

- o Lead School Nurse ___________________________________/___________
- o Principal: ___________________________________/___________
- o Parent: ___________________________________/___________
- o Physician (if applicable): ___________________________________/___________
- o Other: ____

Follow-up information (if applicable, corrective action, etc.):

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______________________________________ ________________________

Printed name of preparer/signature Date

______________________________________ ________________________

Signature of Lead Nurse Date

______________________________________ ________________________

Signature of Principal Date

Updated 6/17 kg