MEDICATION ERROR INCIDENT REPORT

 Date: Time:

# **Student Name:** **ID:**

Medication: RX #:

Medication Type:

☐ Tablet/Capsule ☐ Liquid ☐ Ointment/Cream ☐ Other:

Type of Medication Error:

☐ Wrong Dose ☐ Wrong Student ☐ Wrong Medication Given

☐ Missed Dose ☐ Wrong Time ☐ Given After “D/C” Date

☐ Wrong Route ☐ Missing Medication(s) ☐ Given Without Order

Description of Incident:

Corrective Action Taken:

Additional Action Required:

Date Significant Incident Report completed:

Date Reported to Center Director, Regional Office, and Nurse Specialist:

Signature of Person Making Report Date

Health and Wellness Manager Date

Center Director Date