Ballston Spa
Educating Everyone Takes Everyone
CENTRAL SCHOOL DISTRICT

Office of Special Education
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Director of Special Education

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MEDICATION INCIDENT REPORT FORM

Date of Report: _____

Student Name: _____ Grade: _____

Home Address _____
Street City State Zip

Phone: _____

Date Error Occurred: _____ Time Noted: _____ ❑ AM ❑ PM
Month/ Day/Year

Name of Licensed Prescriber: _____

Medication: _____ Dose: _____ Route: _____ Time: _____

Describe the error and how it occurred. *Use reverse side if necessary:*

_____

_____

_____

Action Taken:

Licensed Prescriber Notified: ❑ Yes ❑ No	Date Notified: *(month/day/year)*	Time Notified: ❑ AM ❑ PM
Parent/Guardian Notified: ❑ Yes ❑ No	Date Notified: *(month/day/year)*	Time Notified: ❑ AM ❑ PM
Other Persons Notified:	Date Notified: *(month/day/year)*	Time Notified: ❑ AM ❑ PM

Describe Outcome: _____

_____

_____

Name: (print) _____ Title: _____

Signature: _____ Date Signed: _____

School Physician's Signature: _____