

Clarksville-Montgomery County School System
HEALTH SERVICES
MEDICATION ERROR REPORT

Date: _____ School: _____

Student: _____ DOB: _____

Date and Time of error: _____

Person administering/assisting with the self-administration of the medication: _____

Medication and dosage prescribed: _____

Describe incident involving error: _____

Describe action taken: _____

Persons notified of error (*** are mandatory to contact**):

*Nursing Supervisor (920-7976) _____ Time: _____

*Principal _____ Time: _____

*Parent _____ Time: _____

Physician (if applicable) _____ Time: _____

Signature of person completing report

Date

PRINT name of person completing report

Title

Forward copy of this report IMMEDIATELY upon completion to Nursing Supervisor via fax (920-9976).