

**PARK COUNTY SCHOOL DISTRICT #6
BOARD OF EDUCATION POLICY**

Med Form 4

MEDICATION ERROR REPORT

Date _____

Name of Student _____

Date and Time of Error _____

Description of Error _____

Persons contacted (include time and date):

School Nurse Name _____ Date _____ Time _____

Administrators Name _____ Date _____ Time _____

Parent Name _____ Date _____ Time _____

Physician _____ Date _____ Time _____

Other _____ Date _____ Time _____

Action Taken _____

Recommendations to Prevent Error From Occurring Again _____

Signature of Person Completing Report _____ Date _____

Signature of School Nurse _____ Date _____

Signature of Principal _____ Date _____

Signature of Nurse Supervisor _____ Date _____

Adopted: 5/20/03

