Medication Error Report

This form is to be filled out by the child care in the event that there is a medication error.

Child's Name: *First* *Last*	Birthdate:	Name of Medication:	Date and Time of Event:

DESCRIPTION

Error:
- ☐ wrong route
- ☐ wrong child
- ☐ wrong medication
- ☐ wrong time
- ☐ wrong dose
- ☐ other:________________

Incident:
- ☐ spit out
- ☐ refused
- ☐ known side effect
- ☐ other:_______

Explanation:

Staff present / witnesses:

ACTION TAKEN

Called:	Taken to Clinic/Hospital:	Notified: call, email, in person	Date and Time:
☐ Poison Control 1-800-222-1222 time:__________	☐ By Parent	☐ Director/Licensee:*	
	☐ By Provider	☐ Parent/Guardian:*	
☐ 9-1-1 time:__________	☐ By Ambulance	☐ DEL Licensor:*	
	☐ Unknown	☐ Social Worker:	
	☐ Not Taken	☐ Other:	
		**** Notification REQUIRED***	

EVALUATION AND PREVENTION PLAN

Describe what will be done or changed as a result of this error (e.g. staff training, improvement in policy/procedure).

SIGNATURES

Staff	Signature:	Date:
Director	Signature:	Date:
Parent/guardian	Signature:	Date:
DEL Licensor	Signature:	Date:

☐ Documented in Incident/Injury Log ☐ Copy made for child's file

This form developed by Snohomish Health District
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