



School Health Program  
MEDICATION OCCURRENCE REPORT

Form Date: 7/9/09

Student's Name:		Date of Birth:
School:	Teacher/Grade:	Diagnosis:

DATE OF OCCURRENCE: \_\_\_\_\_ TIME OF OCCURRENCE: \_\_\_\_\_

**MEDICATION INVOLVED:**

<b>Medication/Dose/Route/Time Ordered for this Student:</b>	<b>Medication/Dose/Route/Time Given:</b>
<input type="checkbox"/> Check if this section not applicable.	<input type="checkbox"/> Check if this section not applicable.

**DESCRIPTION OF OCCURRENCE:** *Check all that apply.*

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Adverse Side Effect            | <input type="checkbox"/> Duplication/Extra Dose         | <input type="checkbox"/> Medication Missing              |
| <input type="checkbox"/> Medication Charted; Not Given  | <input type="checkbox"/> Medication Given: Not Charted  | <input type="checkbox"/> Medication Not Given            |
| <input type="checkbox"/> No Medication Available        | <input type="checkbox"/> Student Did Not Report On Time | <input type="checkbox"/> Student Not Brought On Time     |
| <input type="checkbox"/> Time Variance (> 30 minutes)*  | <input type="checkbox"/> Medication Given: Wrong Dose   | <input type="checkbox"/> Wrong Medication Given          |
| <input type="checkbox"/> Medication Given: Wrong Reason | <input type="checkbox"/> Medication Given: Wrong Route  | <input type="checkbox"/> Medication Given: Wrong Student |
| <input type="checkbox"/> Medication Given: Wrong Time   |   |  |

\*Attach copy of a document that that denotes time variance allowances noted by the medication manufacturer if available.

**DESCRIBE HOW THE OCCURRENCE HAPPENED:**

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**LOCATION OF THE OCCURRENCE:**

- Health Office   
 Classroom   
 Gym   
 Bus   
 Field Trip  
 Other: \_\_\_\_\_

<b>Student's Condition Prior To Occurrence:</b>	<b>Student's Condition Following Occurrence:</b>
<input type="checkbox"/> Alert & Oriented <input type="checkbox"/> Disoriented <input type="checkbox"/> Sleepy <input type="checkbox"/> Other (explain below):	<input type="checkbox"/> Alert & Oriented <input type="checkbox"/> Disoriented <input type="checkbox"/> Sleepy <input type="checkbox"/> Other (explain below):

**NAME(S) OF STAFF INVOLVED OR WITNESSING THE OCCURRENCE:**

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**NOTIFICATIONS MADE:**

Persons Notified	Name & Contact Information of Person Notified	Date & Time of Notification Name of Person Making Notification
Principal		
Parent/Guardian		
Health Care Practitioner		
Health Services / School Nurse Coordinator		

**OTHER ACTIONS TAKEN:**

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\_\_\_\_\_  
Name of Person Preparing Report (Print)

\_\_\_\_\_  
Signature of Person Preparing Report

\_\_\_\_\_  
Date of Report

\_\_\_\_\_  
Name of Principal (Print)

\_\_\_\_\_  
Signature of Principal

\_\_\_\_\_  
Date of Report