Sacramento City Unified School District

Community, Health, and Education Support Services Unit

HEALTH SERVICES DEPARTMENT

INCIDENT REPORT - MEDICATION ADMINISTRATION

Name of School _____

Name of Student _____

Birth Date _____ Today's Date _____ (mo/day/yr) Time_____ am/pm

Date and Time of Error _____

Name of Person Administering Medication _____

Name of Medication & Dosage Prescribed _____

_____

Describe circumstances leading to error: _____

_____

_____

Describe action taken: _____

_____

_____

Persons notified of error:

Supervisor _____

Principal _____

Parent _____

Physician (if applicable) _____

Other _____

Signature (person completing Incident Report) _____

Follow-up information (if applicable): _____

_____