MEDICATION INCIDENT REPORT

Student's Last Name	Student's First Name	Date of Birth	Current Grade
Staff Member Completing This Form		**Date Form Completed**	

Prescribed Medication

Medication Name	Dosage	Date	Time
Explanation of Incident			
Response of school Personnel to incident			

Persons Notified

Position	Name	Date	Time
Principal			
Parent			

Follow-up information if applicable
Click here to enter text.

Signatures

Individual One	Date	Individual Two	Date