St. Lucie Public Schools
Division of Student Services

MEDICATION INCIDENT REPORT

(Please Print)

Name of School _____ **Date and Time of Incident** _____

Name of Student _____ **Birth Date** _____

Name/Position of Person Administering Medication _____ **Prescribed Medication/Dosage/Route/Time** _____

Describe incident and circumstances leading to incident: _____

Describe action taken: _____

Notify individuals listed below either in person or by phone of incident, no later than 24 hours after incident occurs:

	Name	Date	Time
Principal			
Parent/Guardian			
RN Delegator			
Health Services Coordinator			
Other			

Signature (person completing report) _____ **Date** _____

Follow-up information to be completed by RN delegator:

ORIGINAL: Health Services Coordinator

COPY: RN Delegator