Maryland State Department of Education
Office of Child Care
Medication Error Incident Report

Facility/Provider Name: Date:

Address: Phone:

Child's Name: Date of Birth: ☐ M ☐ F

Date Incident Occurred:	Time Noted:
Person Administering Medication:	Prescribing Health Care Provider:
Name of the Medication: _____ Dose: _____ Scheduled time: _____ Route of Administration: _____ Purpose: _____	**Medication Administration Error** _____Wrong Child _____Wrong Medicine _____Wrong Dose _____Wrong Route _____Wrong Time: Time Given____Correct Time____ _____Other(list)_____
Describe the Incident and How it Occurred: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ General Condition of the child: _____ _____	**Action Taken** Name of **Parent/Guardian** Notified: _____ Date _____ Time:_____ **Poison Control** Notified: Yes ___No___N/A____ **911** Called: Yes _____No_____ N/A_____ Program **Director** Notified: Yes___ No___ N/A ____ Date _____Time:_____ Person Notified in **OCC**: _____ Date_____ Time: _____ OCC **Nurse Consultant** Notified: Yes____ No_____ Date_____ Time: _____
Follow up in 24 hours: _____ _____	**Corrective Action**: _____ _____
Signature of the Person Completing Form & Date _____ Position: _____	Director Signature & Date (if applicable) _____