MARYLAND STATE DEPARTMENT OF EDUCATION

Office of Child Care

MEDICATION ERROR INCIDENT REPORT FORM

Facility/Provider Name:	Date:
Address:	Phone:
Child's Name:	Date of Birth:
Date Incident Occurred:	Time Noted:
Person Administering Medication:	Prescribing Health Care Provider:
Name of the Medication & Strength: _____ Expiration Date:_____ 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____ **(1-800-222-1222)** **911** Called: Yes _____No_____ N/A_____ **Director/Provider** Notified: Yes___ No___ N/A ____ Date _____Time:_____ **OCC Licensing Staff** notified: _____ Date_____ Time: _____ **OCC Nurse Consultant** Notified (410) 767-1853 Date_____ Time: _____
Follow up in 24 hours: _____ _____	**Corrective Action Plan and Completed Date:** _____ _____
Signature, Position and Date of the Person Completing Form	Director/Provider Signature & Date (if applicable)