SAGINAW TOWNSHIP COMMUNITY SCHOOLS
MEDICATION ERROR FORM

Student name:_____ Date: _____

Place a check in the category below indicating where an error was made:

__ Child __ Medication __ Dose ___ Time ___Route

Medication given by: _____

Medication error made: _____

Adverse reactions (vomiting, fever, rash, etc.)_____

_____

_____

_____

Who was notified?_____

_____

_____

_____

Time of notification:_____

_____
Signature of person completing record

_____
Signature of Principal

File in CA60