Health Network for Rural Schools
Student Medication Incident Report
(To be completed on the day of the incident)

Student Name:_____Grade: _____

DOB:_____ School:_____

Parent/Guardian: _____Phone: _____

Parent/Guardian notified by: □ Phone □ Note Date: _____ Time: _____

RN Notified: _____ Date: _____ Time: _____
Name

Incident Date: _____ Time: _____

Description of Incident:

Reaction: (include any symptoms and observations with time)

Action taken by employee or student: (to include instructions by nurse/parent/hospital/MD):

_____
Signature of Employee Reporting the Event and Date

_____
Signature of Superintendent and Date

_____
Signature of Nurse or Health Care Provider and Date