

Medication Error Report

10A NCAC 09 .0803 (14) (centers) and .1720 (b)(14) (family child care homes)

The person involved in the medication error completes both pages of this report. Keep original in child’s file. Attach a copy of the **Medication Administration Permission and Record** to this form.

- See the Medication Administration Permission for information and directions about the medication.
- See the Medication Administration Record for the type and dosage of medication given.

Facility name:	Phone number:
Person administering medication:	Classroom name:
Child’s full name:	Date of birth:
Medication administered and dosage:	

Date of medication error:	Time of medication error:
<p>Type(s) of error that occurred</p> <input type="checkbox"/> Gave medication to the wrong child <input type="checkbox"/> Gave the wrong medication <input type="checkbox"/> Gave medication on the wrong date <input type="checkbox"/> Gave medication at the wrong time <input type="checkbox"/> Gave medication by the wrong route <input type="checkbox"/> Forgot to give the medication <input type="checkbox"/> Gave medication without written permission from parent/guardian <input type="checkbox"/> Gave medication after the written permission had expired <input type="checkbox"/> Gave medication that had expired <input type="checkbox"/> Other (be specific): _____ _____ _____	<p>Observations</p> <input type="checkbox"/> No change observed <input type="checkbox"/> Describe changes in child’s behavior: _____ _____ <input type="checkbox"/> Fever _____ ° F <input type="checkbox"/> Coughing <input type="checkbox"/> Diarrhea <input type="checkbox"/> Trouble breathing <input type="checkbox"/> Vomiting <input type="checkbox"/> Change in lips or face color <input type="checkbox"/> Stomachache <input type="checkbox"/> Seizures <input type="checkbox"/> Itching <input type="checkbox"/> Crying <input type="checkbox"/> Rash/hives <input type="checkbox"/> Moaning <input type="checkbox"/> Sweating <input type="checkbox"/> Headache <input type="checkbox"/> Trouble urinating <input type="checkbox"/> Other _____

Action taken	Date	Signature
<input type="checkbox"/> Notified Poison Control Center		
<input type="checkbox"/> Notified parent immediately		
<input type="checkbox"/> Encouraged parent to notify health care professional		
<input type="checkbox"/> Contacted Child Care Health Consultant		
<input type="checkbox"/> Completed Incident Report because child required medical attention		
<input type="checkbox"/> Other (specify):		



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Describe what was done following the error.

For example: The director contacted the parent of the child who received the wrong medication and the guardian of the child who missed her medication. The parent of the child who received the wrong medication called the child's health care professional and was given the advice that one dose of this medication would not cause problems. The guardian of the child who missed a dose called her child's health care professional who said to give the next dose at the scheduled time.

Describe what the facility will do to avoid this type of error in the future.

For example: All early educators administering medication will take the training Medication Administration in Child Care and follow all the steps of safe medication administration. He/she will always check that the name of the child on the Medication Administration Permission form is the same as the child about to receive the medication.

Name and signature of the individual(s) involved in the error:

Print name:

Date:

Signature:

Print name:

Date:

Signature:

Director/Administrator name:

Date:

Director/Administrator signature:

Parent/Guardian name:

Date:

Parent/Guardian signature:

Child Care Consultant name (print):

Child Care Health Consultant name (print):

