Columbus County Schools
MEDICATION ADMINISTRATION INCIDENT REPORT

<table>
<tr><td>School Name</td><td>Student Name</td><td colspan="2">DOB</td><td>Student's Teacher</td><td>Grade</td></tr>
<tr><td></td><td></td><td colspan="2"></td><td></td><td></td></tr>
<tr><td colspan="6">Name/Title of Person Administering Medication:</td></tr>
<tr><td colspan="6">Instructions of administration:</td></tr>
<tr><td>Medication</td><td>Dose</td><td colspan="2">Route</td><td colspan="2">Scheduled Time</td></tr>
<tr><td></td><td></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td colspan="6">Date of Incident or Occurrence:____________________
Describe Incident or Occurrence:</td></tr>
<tr><td colspan="6">Action Taken:</td></tr>
<tr><td colspan="6">Persons Notified of Incident or Occurrence:</td></tr>
<tr><td colspan="6">Name & Title</td></tr>
<tr><td colspan="6">Name & Title</td></tr>
<tr><td colspan="6">Name & Title</td></tr>
<tr><td colspan="6">Name & Title</td></tr>
<tr><td colspan="6">Follow-up:

Signature Date:</td></tr>
</table>

____
Signature of person completing report

____
Title

____
Date