

WEBER SCHOOL DISTRICT
MEDICATION ERROR OR ADVERSE REACTION
REPORTING FORM

Name of Student _____ Date _____

School _____

Name of School Personnel _____

Date and Time of Occurrence _____

Date and Time Reported to Parent _____

Date and Time Reported to Physician (if necessary) _____

Details of Occurrence

Follow Up

School Nurse Signature _____

School Personnel Signature _____

School Principal Signature _____

