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_____