Handout 10.2

OCFS-LDSS-7005 (11/2004)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION ERROR REPORT FORM

- You can use this form or you can create your own master form using this as a guide.
- All areas of this form must be completed.
- The child's parent must be notified immediately of all medication errors.
- Provider should encourage parents to notify the child's health care provider of any medication administration errors.
- The Office must be notified of all medication errors by the close of the following business day.
- If more than one child is involved in the error, an error form must be completed for each child.

Provider/Facility Name:	Facility ID Number:	Facility Telephone Number:
Child's Name:	Child's Date of Birth:	
Date of Medication Error:		

What type of medication error occurred:

- ☐ Incorrect child
- ☐ Incorrect medication
- ☐ Incorrect time *(gave more than 30 minutes before or 30 minutes after time authorized)*
- ☐ Incorrect dose
- ☐ Incorrect route
- ☐ Gave an expired medication
- ☐ Forgot to give medication
- ☐ Consent expired
- ☐ Other ______________________________

Complete this section for all errors using the information provided on the child's approved consent form *(except for incorrect child)*

Name of medication authorized:	Amount/dosage authorized:	Route of adminstration authorized:

Frequency to be administered or signs and symptoms that necessitate the need for the medication as authorized on the consent: ______________________________

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Describe the Incident *(include all individuals involved in the error):*

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Action Taken:

OCFS notified: ☐ Yes ☐ No	Date notified (month/day/year):	Person notified:
Parent/Guardian notified (required immediately) ☐ Yes ☐ No	Date notified (month/day/year):	Person notified:
Encouraged parent to notify health care provider ☐ Yes ☐ No	Date advised (month/day/year):	Person advised:
Other persons notified (ex: health care consultant): ☐ Yes ☐ No	Date notified (month/day/year):	Person(s) notified:

Describe Corrective Action Taken (indicate that an investigation will be done):

Name of person completing this form: *(please print)*	Date form completed:
Signature of person completing this form:	

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