Medical Emergency/ Medication Incident Report Form

Office Use Only – Medical Emergency/ Medication Incident Register Number _ _ _

TO BE COMPLETED BY THE ADULT SUPERVISING MEDICATION ADMINISTRATION OR SUPERVISING BUS/ CLASSROOM/ OFF-SITE ACTIVITY. (Form should be passed to Principal asap and within 24 hours of emergency/ incident.)

Details of person completing the form

Full Name: _____

Contact number:_____

Role: ☐ Teacher ☐ Aide ☐ Other _____ **Signature:** _____

Details of student involved

Full Name: _____

Room: _____

Type of Medical Emergency	**Type of Medication Incident**
Student had medical emergency in school Student had medical emergency on bus Student had medical emergency during off-site activity	Medication not given Medication dropped Medication signed off but not given Medication given but not signed off Medication given to wrong student Wrong medication given to student Wrong dosage of medication given to student Medication given at wrong time Medication found on floor Expired medication found Medication refused by student Student unable to take medication Other _____

Details of the emergency/ incident

Location:

Date:	Time: am/pm

Description of the emergency/ incident _____

_____

_____

_____

_____

_____

_____

Outcome for student _____

_____

Description of any treatment given: _____

_____

Was an ambulance called: YES/ NO: _____

Has parent/ carer/ emergency contact been informed: YES/ NO _____

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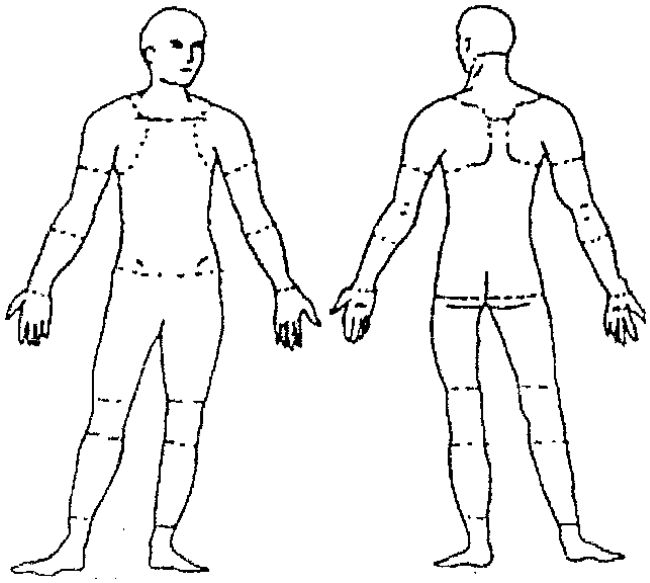
Details of any person(s) injured (photocopy this page as needed)

Full Name: .....

Role: ☐ Teacher ☐ Aide ☐ Student/ Adult Client ☐ Other _____

Part of Body Injured (mark diagram with **X** as appropriate)



The nature of the injury (tick as many as apply)**:**

☐ abrasion/bruise
☐ fracture/ dislocation
☐ concussion
☐ cut/laceration
☐ puncture
☐ other _____

Treatment required at the time (tick as many as apply):

☐ **Not required**

☐ **First Aid** Name of person who supplied treatment: _____

Details of treatment: _____

☐ **GP Visit** Name of GP/ Practice: _____

☐ **Ambulance called** Details of paramedic treatment: _____

☐ **Hospitalisation** Name of hospital: _____

☐ **Parent/ Carer/ Emergency contact called** By: _____ Time: _____

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TO BE COMPLETED BY THE PRINCIPAL IN CONSULTATION WITH ANOTHER APPROPRIATE STAFF MEMBER	
Were policies and procedures followed?	☐ Yes ☐ No
Do policies/ procedures need to be changed?	☐ Yes ☐ No
Is a Risk Assessment needed?	☐ Yes ☐ No
Do Plans need to be changed?	☐ Yes ☐ No
Is additional training needed?	☐ Yes ☐ No
Is a meeting with a parent/ carer needed?	☐ Yes ☐ No
Is input from a Medical Practitioner needed?	☐ Yes ☐ No

Give details of all follow up resulting from this emergency/ incident: _____

_____

_____

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_____

_____

Signature of Principal …… Date: ……

Name of other staff member …… Role: ……

Signature: …… Date: ……

Reviewed by OH & S Representative

Name: …… Signature: ……Date: ……