

Medical Emergency/ Medication Incident Report Form 2022



Office Use Only – Spreadsheet _____ 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: _____

<p>Type of Medical Emergency</p> <p>Student had medical emergency in school Student had medical emergency on bus Student had medical emergency during off-site activity</p>	<p>Type of Medication Incident</p> <p>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 _____</p>
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Details of the emergency/ incident

Location: _____

Date: _____	Time: _____ am/pm
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Description of the emergency/ incident _____

Outcome for student _____

Description of any treatment given: _____

Was an ambulance called: YES/ NO: _____

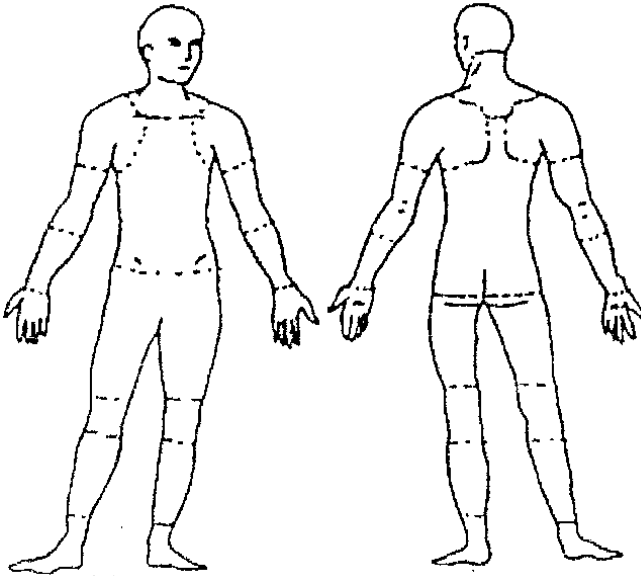
Has parent/ carer/ emergency contact been informed: YES/ NO _____

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):

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> abrasion/bruise | <input type="checkbox"/> puncture |
| <input type="checkbox"/> fracture/ dislocation | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> concussion | |
| <input type="checkbox"/> cut/laceration | |

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: _____

TO BE COMPLETED BY THE PRINCIPAL IN CONSULTATION WITH ANOTHER APPROPRIATE STAFF MEMBER

Were policies and procedures followed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do policies/ procedures need to be changed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is a Risk Assessment needed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do Plans need to be changed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is additional training needed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is a meeting with a parent/ carer needed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is input from a Medical Practitioner needed?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Report entered into Spreadsheet Yes No

Signature of Principal Date:

Name of other staff member Role:

Signature: Date:

Reviewed by OH & S Representative

Name: Signature: Date: