NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
MEDICATION ERROR REPORT FORM

- You may use this form or an approved equivalent to report medication errors.
- All sections of this form must be completed.
- The child’s parent must be notified immediately of all medication errors.
- The Office of Children and Family Services (OCFS) must be notified of all medication errors within 24 hours of the medication error. Verbal notification to Office must occur within 24 hours, followed by submitting this form by mail, fax or email.
- If more than one child is involved in the error, an error form must be completed for each child.

<table>
<thead>
<tr>
<th>PROVIDER NAME:</th>
<th>LICENSE/REGISTRATION NUMBER:</th>
<th>PROGRAM TELEPHONE NUMBER:</th>
</tr>
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<tbody>
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<table>
<thead>
<tr>
<th>CHILD NAME:</th>
<th>CHILD DATE OF BIRTH:</th>
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<table>
<thead>
<tr>
<th>DATE OF MEDICATION ERROR:</th>
<th>TIME OF MEDICATION OF ERROR:</th>
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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 medication consent form. *(except for incorrect child)*

<table>
<thead>
<tr>
<th>NAME OF MEDICATION AUTHORIZED:</th>
<th>AMOUNT/DOSAGE AUTHORIZED:</th>
<th>ROUTE OF ADMINISTRATION AUTHORIZED:</th>
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**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)*:

ACTION TAKEN

OCFS NOTIFIED VERBALLY:
☐ Yes    ☐ No

FORM SUBMITTED TO OCFS:
☐ Yes    ☐ No

PARENT NOTIFIED (Required Immediately):
☐ Yes    ☐ No

OTHER PERSONS NOTIFIED
(Ex. Health Care Provider, Health Care Consultant):
☐ Yes    ☐ No

DATE NOTIFIED (mm/dd/yy):

TIME(AM/PM):

PERSON NOTIFIED:

DATE NOTIFIED (mm/dd/yy):

PERSON(S) NOTIFIED:

Describe Corrective Action:

NAME OF PERSON COMPLETING THIS FORM: (Please Print):

DATE FORM COMPLETED:

SIGNATURE OF PERSON COMPLETING THIS FORM:

X