



PRN Medication Incident Report

Date: _____ Time: _____ Student: _____

Person Preparing This Report: _____

Condition Prior to Intervention:

Location of Incident: _____

Known Duration of Condition Prior to Intervention:

Length of Seizure(s): _____

Medication administered upon well-informed decision of:

- Myself the Student the Teacher Classroom Staff Administration Parent
 Other _____

Medication and Dosage Administered:

Medication Type(s):

- Over-the-Counter Rescue

Refill Needed? Y N Notes: _____

Other Staff Involved:

How was student monitored: In-Person Security Camera

