Mississippi Department of Human Services
Division of Youth Services

---------- MEDICATION ERROR REPORT ----------

Youth Name:	DYS No.	Living Unit

Signature and Title of Person Completing This Section	Date	Time AM PM

Physician's Findings and Actions, following your assessment of the youth.

Signature and Title of Person Completing This Section	Date	Time AM PM

Supervisor's Evaluation of Error Incident - Include cause and action taken; indicate corrective measures to prevent further errors of similar nature.

Signature and Title of Person Completing This Section	Date	Time AM PM

Conclusive Findings/Recommendations - What processes were identified that need analysis or improvement.

Signature and Title of Person Completing This Section	Date	Time AM