PARKWAY MEDICATION ADMINISTRATION DELEGATION
TRAINING RECORD

School/ Delegatee:
Date:

MEDICATION ADMINISTRATION DELEGATED*	**Initial & Date**	
	RN	**UAP**
Medication Administration/General: Describes medication administration in school, individual health care plans (IHP) and 504 plans, supervision of self-carry, training and delegation. _____Reviewed students' medication orders _____Reviewed students' IHPs and 504 plans, if applicable _____Reviewed student's self-carry agreement, if applicable		
General Medication Administration Procedure:		
Demonstrates correct performance of medication administration. Has reviewed all medication orders and knows where medications and medication log are stored.		
Washes hands before and after procedure.		
Gives proper dose of medication at proper time. States 5 rights		
Compares labeled medication container with written order.		
Reads label 3 appropriate times.		
Checks student identity with name on label properly.		
Explains procedure to student if necessary.		
Checks expiration date on label.		
Documents medications given correctly.		
Maintains security of medication area.		
Describes proper actions for medication refusal, field trip, medication error.		
States appropriate times/situations for notification of school nurse or Director of Health Services. Identifies paired school nurse.		
Emergency Medications		
Inhaler/Nebulizer:		
States symptoms of asthma exacerbation, location of emergency inhalers and nebulizer and asthma action plan.		

Demonstrates correct procedure for administration of inhaler and nebulizer.		
States follow-up procedures.		
EpiPen:		
States symptoms of allergic reaction, location of medication and emergency plan.		
Demonstrates with trainer, correct procedure for administration.		
States follow-up procedures.		
Diastat: Check if not applicable_____		
States understanding of order, location of medication and emergency seizure plan.		
Demonstrates proper positioning of child and procedure for administering medication.		
States aftercare needed.		

DELEGATION AUTHORIZATION

I have provided skills assessment training to _____ to administer medications according to district policy and procedures. She/he has demonstrated knowledge and understanding of the policies and procedures listed above.

RN Signature: _____ Initials: _____ Date: _____

I have been instructed in the district's medication policy and administration procedures. I understand that I am to administer medications to students according to these procedures and as delegated to me by the school nurse and principal. I understand that I am to report immediately to the school nurse any new orders, change of medication orders, changes in student health status, and discovery of a medication error of variance. I understand that I may not delegate this task to any other person.

Delegatee Signature: _____ Initials: _____ Date: _____

PLACE COPY OF THIS FORM IN THE MEDICATION LOG AND SEND ORIGINAL TO DIRECTOR OF HEALTH SERVICES.

1/2016